Preventing Disabling Conditions: The Role of the Private Sector

Proceedings and Recommendations of the National Conference

September 11–13, 1994, Washington, DC

Michael Marge, Ed.D., editor

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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Sponsored by:

American Disability Prevention
and Wellness Association

Centers for Disease Control and Prevention

Metropolitan Life Insurance Company

J. M. Foundation

And with the generosity of:

President's Committee on Mental Retardation

The Dole Foundation

Paralyzed Veterans of America

United Cerebral Palsy Associations

Spina Bifida Association of America

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Prefaces

CENTERS FOR DISEASE CONTROL AND PREVENTION

IN 1988, The Centers for Disease Control and Prevention established the Disabilities Prevention Program (DPP). The purposes of the program are (1) to develop an epidemiology of disability, (2) to build state- and community-level capacities to plan, implement, and maintain coordinated programs for the prevention of disabilities, (3) to advance our knowledge about the prevention of secondary disabling conditions in persons with disabilities, and (4) to coordinate federal programs and efforts in the prevention of disabling conditions.

Over the years, since the inception of the DPP, we have sponsored many national, state, and local efforts in prevention in general, and in disability prevention in particular. In 1989, we requested that the Institute of Medicine (IOM), National Academy of Sciences, study and report on the status of disability prevention in America. The result of this two-year project was a landmark report and publication, *Disability in America: Toward a National Agenda for Prevention*. One of the recommendations of the IOM Study Group was for better coordination of resources and programs devoted to the prevention of disabilities in the public and private sectors. Also, at about the same time, the Office of Disease Prevention and Health Promotion, Department of Health and Human Services, produced *Healthy People 2000*, a national blueprint for improved health through prevention. This publication also recommended coordination of prevention programs and services in the private sector with such programs and services in the public sector.

In order to carry out the recommendations for coordination of the prevention efforts of the private and public sectors in *Disability in America* and *Healthy People 2000*, and in order to meet one of its chief missions, the DPP was pleased to be a sponsor of this conference. Of special interest was the plan to gather representatives from diverse programs within the private sector and request that these decision makers interface with key individuals from the public sector on topics related to ways in which effective coordination can take place. Also, the conference plan was to obtain the cosponsorship of both public and private sectors with the greatest emphasis on the private sector.

The DPP was pleased to learn that the Metropolitan Life Insurance Company

and the J.M. Foundation would cosponsor the conference with the Centers for Disease Control and Prevention. Symbolically, coordination between public and private sectors began with the sponsorship of this conference. The additional support provided by The Dole Foundation, Paralyzed Veterans of America, United Cerebral Palsy Associations, Spina Bifida Association of America, and the President's Committee on Mental Retardation further emphasized the coordination and cooperation of this new public-private coalition.

We have reviewed the recommendations from this conference and feel that many of them need immediate attention. One of the more significant recommendations called for a continuation of the dialogue between representatives from the public and private sectors with a second conference in the near future. A complex topic that will certainly require further exploration and discussion is the need for greater facility in communication between the two sectors. It was felt that the public sector wittingly and/or unwittingly imposes barriers to communication and progress. These barriers are disincentives for the private sector to seek cooperation and coordination with public agencies on projects with a common objective.

The DPP expresses its sincere thanks to all those who planned this conference and to the participants who provided excellent recommendations through their speeches and discussion groups. We look forward to addressing these recommendations in the months and years to come.

~ *Larry Burt*
Director, Disabilities Prevention Program, National Center for Environmental Health

THE METROPOLITAN LIFE INSURANCE COMPANY

METLIFE HAS HAD a long history of support for programs that encourage good health and wellness. For more than 100 years, we have been dedicated to improvements in America's health through a division of our company known as Health and Safety Education. This division has two major purposes: (1) to promote public understanding of healthy living principles and (2) to serve as a reliable national health education resource.

Since 1871, when MetLife began delivering health and safety messages to employees and policyholders, the Company has played a significant role in increasing the public's awareness of improved and safe health methods and behaviors. For example, since the early 1900s, MetLife has cooperated with private and public health agencies to communicate the importance of immunizations in combatting childhood diseases.

For more than a decade, the Stay Well Series has been available to the general public and it has now expanded to present a full range of preventive health and safety topics, covering the entire life cycle from birth to youth, middle age, and later years.

Another example of MetLife's commitment to prevention is its national project to combat school-age alcohol and drug abuse. Through public television and grassroots community efforts, the prevention project has reached thousands of concerned citizens. Since 1983, 11,000 town meetings have been held across the nation to help form local task forces to curb alcohol and drug abuse through education, intervention, prevention, and treatment.

Good health is dependent upon three factors: (1) health protection, which is generally the responsibility of the local, state, and federal governments, (2) access to quality health care, and (3) individual lifestyle. Although MetLife has addressed each of these factors for many decades, in recent years we have focused on the need for greater personal responsibility for improved health and wellness. We believe that many more individuals will enjoy lives of good health and wellness if they adopt the principles of a healthy lifestyle.

As a major private-sector company dedicated to good health and wellness, MetLife is pleased to cosponsor this conference. The two focuses of the conference are of considerable interest to our company—the prevention of disabling conditions in persons with and without disabilities, and delineation of the role of the private sector in prevention.

Of particular interest to MetLife is the conference's emphasis on the prevention of primary and secondary disabling conditions. Until recently, national efforts in prevention have measured progress in health care using statistics on mortality rates.

Thanks to the efforts of the American Disability Prevention and Wellness Association and the Centers for Disease Control and Prevention, progress in health care is now being measured with reference to morbidity/disability as well as mortality statistics. In the area of prevention, MetLife agrees that attention must be given to preventing disabling conditions, especially the acquisition of additional health complications in persons with disabilities.

Since the private sector represents a significant portion of the health care industry in the United States, it is essential that its current and future roles be explored and discussed. A national program for preventing both premature death and premature disability will require the cooperation of the private and public sectors. We look forward to studying these conference proceedings and recommendations.

~ *Russel Iuculano*
Vice President for Governmental Affairs, Metropolitan Life Insurance Company

THE J.M. FOUNDATION

FROM ITS INCEPTION in 1924, the J.M. Foundation has been dedicated to improving the lives of people with disabilities. The Foundation supports programs in several related fields including rehabilitation of people with disabilities, prevention and wellness with an emphasis on individual responsibility for health, health-related public policy research, and prevention of alcohol abuse and alcoholism. The Foundation directors also have a strong interest in educational activities that strengthen America's pluralistic system of free markets, entrepreneurship, voluntarism, and private initiative.

We are pleased to sponsor this conference in collaboration with the Metropolitan Life Insurance Company and the Centers for Disease Control and Prevention. The topic, "Preventing Disabling Conditions: The Role of the Private Sector," is of national importance and addresses two of our historic interests. First, it focuses on the *prevention* of disabilities which is essential if we are to stem the rising cost of health care for catastrophic illnesses and disabling injuries. Second, the conference explores the valuable role of the private sector in efforts to prevent disability.

To be effective, prevention programs should include both prevention of premature death and prevention of disabling conditions. A comprehensive strategy for preventing disabilities encompasses the prevention of disabilities in nondisabled persons as well as the prevention of secondary disabling conditions in persons with disabilities.

Several years ago, our Foundation focused national attention on this issue by helping to establish Syracuse University's Center for the Prevention of Disabilities. The foundation also supported the first National Conference on the Prevention of Disabilities, held in Syracuse, New York, in 1985. Since then, we have witnessed an explosion in scientific inquiry into the epidemiology, causes, and effective prevention of disabling conditions.

The findings and recommendations of this conference should serve as a beacon for researchers, educators, and practicioners who will shape the future directions of prevention. We anticipate that the private sector, especially business and industry, will play a much greater role in preventing premature death and disability in communities across America.

~ Christopher Olander
Executive Director
The J.M. Foundation

Executive Summary

INTRODUCTION

DURING THE DEBATE over health care reform in 1993–94, the role of prevention of premature death and disability was not addressed adequately. The debate centered on ways to reduce the exploding costs of health care delivery for sick people. Much of the rapid rise in costs was attributed to catastrophic illnesses and disorders, like birth defects, cancer, stroke, heart disease, progressive neurological disorders, diabetes, arthritis, osteoporosis, and vision disorders. The underlying assumption was that health care interventions in America should be primarily concerned with these devastating health conditions on a crisis-by-crisis basis. Instead, the debate should have recognized a dual mission for health care reform: using the most efficient and cost-effective ways to treat health conditions with the best possible resources while, at the same time, instituting programs to prevent premature death and primary and secondary disabling conditions. Unfortunately, the prevention component of a national health care plan was excluded from the debate. It is this component that holds the most promise for reducing health care costs in America.

Another issue which was not addressed adequately in the debate over health care reform was the role of the private sector in the prevention of premature death and primary and secondary disabling conditions.

The first national conference of the American Disability Prevention and Wellness Association examined the role of prevention in a national health care plan. Support for the Centers for Disease Control and Prevention's commitment to the health promotion and disease and injury prevention objectives of *Healthy People 2000* served as a point of departure. Compared with previous national plans for prevention, *Healthy People 2000* places more emphasis on (1) the significance of the private sector in developing and implementing the plan, (2) the reduction of morbidity as well as the reduction of mortality, and (3) the prevention of primary disabling conditions and the prevention of secondary disabling conditions among people with disabilities. Efforts to enlist the cooperation of the public sector in attaining the objectives of *Healthy People 2000* have achieved limited success. While participation of the private sector has increased, emphasis on preventing primary and secondary

disabling conditions is still insufficient.

The conference was organized around four purposes: (1) to clearly delineate an effective role for the private sector in implementing a national effort to prevent primary and secondary disabling conditions, (2) to develop recommendations for ways to encourage greater participation and cooperation of the private sector, (3) to identify examples of effective projects in prevention that include the participation of both the private and public sectors, and (4) to encourage the development of a network of people interested or involved in disability prevention.

The private sector was divided into 11 categories, including:

- *Voluntary organizations* that are dedicated to health and disability issues (e.g., United Cerebral Palsy Associations, the Arc, and the Spina Bifida Association of America)
- *Professional associations* concerned with health and disability issues (e.g., the American Medical Association, the American Public Health Association, the American Speech-Language-Hearing Association, and the American Psychological Association)
- *Business and industry*, further divided into
    a. small businesses
    b. moderate and large businesses
- *Labor organizations*
- *Private and corporate foundations*
- *Religious institutions*
- *Health professionals* (physicians and other health care providers)
- *Media* (print and electronic)
- *Schools* (preschools, elementary, and secondary schools, adult education, colleges, and universities)
- *Independent living centers for persons with disabilities*
- *Consumers and their families* (persons with and without disabilities and members of their immediate families)

THE CONFERENCE

The conference was held September 11–13, 1994, at the Omni Shoreham Hotel in Washington, DC. On the first evening, participants gathered for a plenary session that included introductory statements from two sponsors: Dr. Michael Marge, president of the American Disability Prevention and Wellness Association; and Mr. Larry Burt, director of the Disability Prevention Program, National Center for Environmental Health, Centers for Disease Control and Prevention. The keynote speaker for the evening was Russel P. Iuculano, Esq., vice president for Governmental Affairs, Metropolitan Life Insurance Company. Mr. Iuculano spoke

on "Preventing Disabling Conditions: The Role of the Private Sector." Conference participants also enjoyed the opportunity to meet a distinguished guest, Helen Thomas, the award-winning United Press International journalist, widely known as "the dean of the White House press corps," who spoke about the importance of prevention as a component in public health.

During the next two days, the conference followed the following format:

SEPTEMBER 12

Morning:

Invited Speakers: Richard Jackson, M.D., director of the National Center for Environmental Health, CDC; Michael McGinnis, M.D., director, Office of Disease Prevention and Health Promotion, DHHS; Lex Frieden, Ph.D., senior vice president, The Institute for Rehabilitation and Research, Houston, Texas.

Panel-Participant Discussion: Speakers included Andrew Imparato, Esq., U.S. Senate Subcommittee on Disability Policy; Christy Gilliland, advocate for the Disabled; Susan Olson, director of Well Power, UNUM of America Insurance Company. Reactors to the speakers' presentations included Kathy Kirchner, Washington Business Group of Health; Sunny Roller, University of Michigan; Patricia McGill Smith, National Parent Network on Disabilities; Ruth Brannon, Department of Research, National Rehabilitation Hospital.

Luncheon Speaker: Fred R. Patterson, management consultant, Johnson & Johnson, Office of Corporate Contributions.

Afternoon:

Participant Interaction in Small Group Discussions: Six groups were formed, each representing an area of the private sector: Group A: business, industry, and labor; Group B: professional and voluntary organizations; Group C: independent living centers, consumers, and their families; Group D: private health agencies, rehabilitation centers, and hospitals; Group E: schools (elementary, secondary, and postsecondary); and Group F: health professions. Each of the groups addressed two questions, (1) "What is the role of the private sector in preventing disabling conditions?" and (2) "How do we promote and support the private sector's participation in preventing disabling conditions?"

SEPTEMBER 13

Morning:

Plenary Session with Invited Speaker: Dean Witherspoon, president of Health Enhancement Services, followed by participant discussion.

Participant Interaction in Small Group Discussion: The six groups discussed

a third question, "The private sector/public sector connection: what are the points of cooperation in preventing disabling conditions?"

***Luncheon Speaker*:** Judy Feder, principal deputy assistant secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Afternoon:

***Plenary Session and Conclusions*:** Glen White, Ph.D., director of the Institute for Rehabilitation and Research, University of Kansas, chaired (1) the presentations of the summaries of the discussion groups with recommendations, and (2) open forum on topics, summaries, and further recommendations.

Closing Remarks: Fred Krause, former executive director, and Michael Marge, president, American Disability Prevention and Wellness Association.

Conference participants included persons with diverse interests and expertise in prevention and disability. The small group discussions involved representatives from business and industry, the schools, voluntary organizations, professional organizations, community programs, the health professions, independent living centers, consumer groups, and state and federal governments. A considerable number of participants had personal experiences with disabling conditions and provided valuable insights and recommendations.

SUMMARY OF THE DISCUSSIONS AND RECOMMENDATIONS

The speakers and the participants provided extensive advice and good counsel on the role of the private sector in preventing disabling conditions. Among the many excellent recommendations, the following are worthy of special note:

1. Health promotion and prevention of disabling conditions should be regarded as part of a continuum of services provided to individuals throughout the life span, in response to diverse and changing needs.
2. The private sector has a role to play in promoting health and preventing disease and injury among its own employees. Many studies trace positive outcomes and cost savings to employer health promotion and prevention programs.
3. Members of the private sector need to reach out to each other, especially to small business organizations, to pool resources and collaborate on health-related programs. Shared resources could lead to cooperative employee assistance programs, health education, fitness/exercise programs, safety programs, cholesterol and health screening, and disability management.
4. The private sector should form partnerships with the public sector to proactively support measures for primary prevention and the prevention of secondary disabling conditions. Potential sources of financial support

include federal/state/local governments, and corporate and private foundations. The emphasis should be on encouraging community planning and improvement of community services and quality of life. Quality of life means the attainment of personal, social, and physical well-being for all.

5. The federal government needs to do a better job of addressing prevention by reconciling conflicting policies and ensuring cooperation among and between federal agencies. The role of the federal government in prevention is essential but must be handled with sensitivity to unintended consequences of bureaucracy and legislation that can inhibit creative, progressive prevention efforts.
6. Efforts to plan and implement programs for prevention of disabling conditions must include significant representation by persons with disabilities. Private/public sector efforts must be sensitive to the perceptions and needs of these individuals. Promotion of programs to prevent disabling conditions must not demean or alienate our advocates through the use of insensitive terminology, statements about outcomes, or insulting examples. It must be remembered that the ultimate purpose of prevention is to attain a life of personal, social, and physical well-being for all.

The conference concluded with a request from the participants to continue the discussion about the private sector's role in preventing disabling conditions and the establishment of a network for continued communication through the American Disability Prevention and Wellness Association.

~ Michael Marge
President, American Disabilitiy
Prevention and Wellness Association

Preventing Disabling Conditions: A Private Sector Perspective

Russel P. Iuculano, Vice President
Metropolitan Life Insurance Company

SOME OF YOU have asked about the reasons for MetLife's support for this conference. In response, let me note that MetLife has a long history of support for health programs that focus on the prevention of premature death and disability. Our company's cosponsorship of this conference is just another expression of our commitment to these objectives.

> *"By providing the structure and the requirements for accountability, managed competition allows competing private programs to bring to bear the creativity, innovation, and consumer responsiveness needed to meet American citizens' expectations of full access to affordable high-quality health care."*

For more than one hundred years, MetLife has been dedicated to improvement of America's health through a special division of our company for Health and Safety Education. This division, known as H & S, has two major goals—it seeks to promote public understanding of healthy living principles, and it serves as a reliable national health education resource.

Our efforts in this area date back to 1871, when we began distributing health and safety messages to MetLife employees and policyholders. In 1909, a Visiting Nurse Service was established, the first of its kind in the industry. During its 44 years in existence, over 20 million policyholders received more than 100 million nursing visits.

In 1916, MetLife began a seven-year effort in cooperation with the National Tuberculosis Association, and when the project ended in 1923, TB mortality in the demonstration area had dropped 68 percent.

Today, H & S monitors national trends and developments in public health and responds to significant health problems. Its efforts include promotion of health and safety through television, video, radio, various publications, and films, as well as demonstration projects and research in cooperation with national, state, and local health organizations. As various public health problems are brought under control and others arise, programs change to meet the current health challenges.

Let me give you a few examples of our continuing activities:

- For more than a decade, the Stay-Well Series has been available to the general public and it has now expanded to present a full range of preventive health and safety topics covering the entire life cycle from birth through youth, middle age, and later years.
- Since the early 1900s, the H & S Division has focused on the importance of children's immunizations in combating childhood diseases. Over the years, national efforts have been made, using radio and television announcements and advertisements in national magazines and newspapers, to raise public awareness of the importance of immunizing children.
- Since 1983, H & S has cosponsored a national project to combat school-age alcohol and drug abuse through public television and grassroots community efforts. Concerned citizens have attended 11,000 town meetings across the country, and more than 1,000 MetLife employees have participated in forming local task forces to curb alcohol and drug abuse through education, intervention, prevention, and treatment in their communities.
- MetLife's height and weight tables are another example. Since the publication of Metropolitan's first weight tables in 1942 and 1943, our height and weight data have been considered the standard for the United States and are regularly reprinted in medical texts, professional pamphlets and journals, health department publications, hospital clinics, and public and private doctors' offices.

METLIFE'S POSITION ON HEALTH CARE

Since MetLife has been an active participant in the health care debate, Dr. Marge has asked me to summarize our position on health care.

MetLife supports efforts to achieve a health care system accessible to all Americans through the enactment of a federal reform bill based on the principles of managed competition. Such a bill would provide needed structure for a competitive market of private accountable health plans that integrate the delivery and financing of health care. By providing the structure and the requirements for accountability, managed competition allows competing private programs to bring to bear the creativity, innovation, and consumer responsiveness needed to meet

American citizens' expectations of full access to affordable high quality health care. Under managed competition, Accountable Health Plans (AHPs), such as HMOs, would be federally certified by a National Health Board on the basis of their ability to promote patient health and to meet quality, cost, and patient satisfaction standards. These AHPs would be required to offer a standard, federally defined uniform benefits plan.

MetLife understands that this system of AHPs would dramatically change the way we do our business. Nevertheless, we are committed to it and have, in fact, already invested billions of dollars in the process. We also support additional reforms that would be required by a successful managed competition system.

As the debate has unfolded, we have been very concerned about the Administration's proposed use of insurance premium caps as a cost-containment measure. In our opinion, price controls would stifle competition, establish a huge bureaucracy to determine the correct price for a major sector of the U.S. economy, and deflect the investment flow of private capital that is necessary to develop, grow, and expand accountable health plans across the country. Our position is that instead of looking to control and regulate, we should pursue a national system of AHPs that provide continuously improving quality health care at competitively driven, affordable prices.

Toward that end, MetLife supports legislation that significantly improves access to private health coverage through insurance-market reforms that provide availability, portability, continuity, and restricted use of preexisting condition limitations. We also support making information available to consumers concerning competing health plan pricing and performance, and legislation that would put greater emphasis on preventive care, including immunization. Copies of MetLife's brochure explaining its position on health care in more detail are available at the registration desk.

After a gruelling summer that produced several weeks of debate on health care reform, but no measurable progress toward passage of a bill, members of Congress have finally gone home for a short recess, nearly two weeks later than scheduled. Both houses of Congress are expected to resume sessions tomorrow, September 12th. Members of the leadership on both sides of the Capitol say that comprehensive reform is no longer possible. They are setting their sights on an incremental bill, if any. ■

Preventing Disabling Conditions: A CDC Perspective

Richard J. Jackson, M.D.
Director, National Center for Environmental Health
Centers for Disease Control and Prevention

I AM A PUBLIC health physician. As a public health physician, I, along with my colleagues, am taking care of one large body comprised of many people. The public health physician must observe the vital signs of the patient. Public health physicians use epidemiology and surveillance (statistics, case reports, etc.) to measure the vital signs of the community.

The vital signs tell us that 20 percent of the American population has some kind of disability (49 million people, according to the 1990 Census). In terms of this large body, the two arms are affected and need care. The annual national costs of disabilities exceed $170 billion, including an estimated $85 billion in federally supported programs for benefits and services to people with disabilities (IOM and SIPP, Bureau of Census).

Historically, disability prevention activities have focused on preventing the three major causes of primary disabilities: birth defects and developmental disabilities, chronic diseases, and injuries. These efforts are of critical importance in preventing mortality and in preventing the diseases or conditions that lead to disabilities.

Not all disabilities are prevented. For the 20 percent of Americans who do have a disability, we must consider the secondary conditions that impact people with disabilities. The consequences of secondary conditions can be severe and can have great health and economic impact for the person with a disability. We must encourage those actions that promote the productivity and independence of people with

> *"While this conference emphasizes the role of the private sector, in all of our discussion, let us keep foremost in our minds the primary partners—people with disabilities."*

disabilities and their integration into the community.

The Disabilities Prevention Program (DPP) is a collaboration of several CDC programs. The DPP complements the CDC's mission to promote health and quality of life by preventing and controlling disease, injury, and disability.

The DPP is concentrating on three major areas of activities:

- providing a national coordinating focus for the prevention of disabilities and secondary conditions;
- improving the scientific knowledge base needed to design, implement, and evaluate interventions that prevent disabilities; and
- building capacity at the state and community levels to coordinate and conduct disabilities prevention activities.

The focus of this conference is the private sector. The private sector must be an active partner if we are to be successful in preventing secondary conditions and in increasing the productivity and independence of persons with disabilities.

In *Disability in America*, the Institute of Medicine's (IOM) second recommendation is for developing an enhanced role for the private sector. This conference is a part of that process. The IOM presents five strategies for preventing disabilities and the private sector has a role in each.

- *Organization and Coordination*: Active participation in the development of a national plan for prevention, and in development of disability policy.
- *Surveillance*: Participation in development and review of conceptual frameworks, classification, and measurements of disability. Once consensus is achieved, this strategy will focus on encouraging adoption by all public and private agencies that gather data on disabilities (e.g., insurance, health care providers, and researchers).
- *Research*: Funding and support of disability research. In addition to basic biomedical areas, research should focus on practical and affordable assistive technologies, and on understanding the disabling process. Prevention of secondary conditions, improvement of functional status, and improvement of quality of life should be emphasized.
- *Access to Care and Preventive Services*: Providing a system of accessible, affordable, quality health care and personal assistance services for all should have an enormous beneficial effect on the disabling process and on prevention of secondary conditions. In addition, vocational services such as utilization of assistive technologies, counseling and work-readiness evaluations, job training, job placement, and worksite accommodations are needed.
- *Professional and Public Education*: The attitudes and behaviors of the public and of professionals will either facilitate effective coping and productive

lives for persons with disabilities or erect additional barriers. Why not apply the marketing strategies that the private sector uses to sell goods and services to educate and inform professionals and the public about the disabling process and about people's abilities? This would do much to break down many attitudinal and behavioral barriers.

This conference is only one discussion in what, hopefully, will be a continuing dialogue and productive partnership between the public and private sectors. While this conference emphasizes the role of the private sector, in all of our discussion, let us keep foremost in our minds the primary partners—people with disabilities. ▩

Healthy People 2000 and Disability Prevention

J. Michael McGinnis, M.D.
Director, Office of Disease Prevention and Health Promotion, DHHS

Debra Rothstein, Ph.D.
Program Analyst, Office of Disease Prevention and Health Promotion, DHHS

THANK YOU FOR the invitation to be here today, and we congratulate you on your success in putting together the First National Conference of the American Disability Prevention and Wellness Association. Health care has been probably the number one topic in the news this year. As the debate continues about how much and what measures are needed to improve the current system, a discussion of prevention in the context of disabling conditions is very important and timely.

> *"With a focus on prevention, the health promotion and disease prevention needs of people with disabilities become even more compelling."*

Today we are going to present an update of ongoing activities on the nation's prevention agenda, *Healthy People 2000*. As a disease prevention and health promotion plan for the 1990s, *Healthy People 2000* addresses not only the prevention of premature death and disease, but also the prevention of disabilities and related secondary conditions. We like to think of *Healthy People* as an architectural project, involving thousands of individuals from around the country working together to give it form and substance. Let us take a few minutes to remind ourselves of the process. Beginning in 1987, the U.S. Public Health Service—with the assistance of the Institute of Medicine of the National Academy of Sciences—held regional hearings

across the country from Birmingham to Detroit, from New York to Los Angeles. Public testimony was a significant component of these hearings and other sessions, which included health professionals and providers, individuals, employers, private organizations, and public agencies. It all led to development of a prevention agenda for all Americans.

THREE BROAD GOALS

Using *Healthy People 2000* as a framework, three broad national goals have been set. The first goal is to increase the span of healthy life. The emphasis here is on increasing the *quality* of life for all Americans through prevention of disabilities and their consequences. This highlights the elimination, or compression, of morbidity from preventable disease and disability as the true aim of prevention. Associated with this is the need to reduce the prevalence of risks to health, and to increase healthy behaviors associated with risk reduction.

We have made tremendous strides in increasing life expectancy. During the course of this century, life expectancy at birth has increased by almost 60 percent from 47 years in 1900 to over 75 years in 1990. This progress has been largely due to scientific and public health advances in conquering life-threatening and communicable diseases. In fact, our best guess is that only about five of the nearly 30 years of life expectancy gained this century can be attributed to improved medical treatment. This turns our attention, however, to the current leading causes of death and disability, which are chronic diseases such as those of the cardiovascular system, lung and liver, and injuries. It also calls attention to quality of life issues, and emphasizes the need to reduce unnecessary suffering and disability.

Limitation of major life activities like self-care, recreation, school, or work due to chronic conditions and disabilities is a significant factor determining years of healthy life. The latest data from the National Center for Health Statistics indicate that of an expected 75.4 years of life, some 11.7 of those years (15 percent) are dysfunctional as measured by limitations in the ability to perform daily activity.

The second goal of *Healthy People 2000* recognizes the relatively poor quality of health services to disadvantaged populations—those with low income, racial and ethnic minorities, youth and older adults, and those with disabilities. This goal seeks to reduce disparities, with a focus on improving health status and health outcomes for these special populations.

Let us share one example concerning the receipt of clinical preventive services that illustrates the importance of this goal. Data from 1991 indicate that for all adult women, 76 percent had received a pap test within the past three years. For women with disabilities, this figure was 66 percent. Similarly, in 1992, 51 percent of women over the age of 50 had received a breast exam and mammogram within the past

two years. Only 44 percent of women with disabilities had received this breast cancer preventive service. Thus, with the second goal we have an explicit recognition that real progress in public health demands special attention to those who are at highest risk.

The third goal is to achieve access to preventive services for all Americans. In 1990, Americans made a commitment to achieving universal access to basic primary care and preventive health services. As the debate on health care reform continues, we have in the forefront the question of how we can achieve this goal within reasonable cost constraints.

PRIORITY AREA STRUCTURE

To help meet these goals, 300 specific objectives were set in 22 priority areas, or chapters, ranging from nutrition to mental health, to heart disease, to education/community-based programs, to diabetes and chronic disabling conditions. Quantifiable targets were established for improvements in health status, risk reduction, and health service delivery. These objectives were also broadly organized within each chapter, according to their contribution to health promotion, health protection, or preventive services.

Health promotion focuses on personal choices and lifestyle behaviors such as smoking, exercise, diet, and safe sex. Personal responsibility is an integral component here. Health protection addresses the physical and social environments in such areas as occupational safety, food and drug safety, and regulatory measures. Highway safety is an excellent example of where progress has been made. Through the use of seat belts and child safety seats, a 32 percent decline in fatal car crashes has been achieved over the past 15 years. Preventive services include interventions that can be delivered by health professionals, including prenatal care for all pregnant women, and blood pressure and cholesterol screening.

In addition to the 300 objectives, there are 223 specific population targets focusing on eliminating the disparities that exist for segments of the population that are at higher risk for disease or disability than the total population. Many of the most vulnerable groups are also the fastest growing groups. The extent to which we focus our efforts to meet the established year 2000 targets for these subobjectives is critically important.

Recognizing that collecting information and monitoring our progress across all of the objectives is crucial, we also built into the framework specific objectives by which we can track our progress in meeting our targets. We are now in the fourth year of the decade and still counting, and the National Center for Health Statistics has recently drawn some conclusions regarding our progress to date:

- Six percent of the objectives have already been achieved.

- Progress toward the year 2000 targets has been made on an additional 36 percent of the objectives.
- The trend is moving away from the target or showing mixed results for 20 percent of the objectives.
- Data are not yet available to evaluate progress for 21 percent of the objectives.
- Six percent of the targets have newly established baselines and another eight percent are still awaiting baselines.

DISABILITY PREVENTION

I will now turn the focus more specifically to prevention of disabilities, including the prevention of secondary disability among those who already experience serious or chronic disease conditions. Disabilities may be physical or mental, and they may include motor or sensory limitations. They may be caused by disorders related to genetics, disease, or injury. Whatever the cause or consequences, disabilities present major problems for Americans. About 35 million Americans have impairments that interfere with daily activities, and more than 9 million have functional limitations so severe that they cannot work, attend school, or maintain a household. An additional 2 million people live in chronic-care settings as a result of functional limitations related to disabling conditions.

With a focus on prevention, the health promotion and disease prevention needs of people with disabilities become even more compelling. These individuals face special health risks, the risks of secondary health problems that arise from, or are related to, the primary disease or disorder. To the extent that adequate health care is not provided, they face accelerated problems that challenge their efforts to maintain active and independent lifestyles.

Immobility increases the risk of metabolic, circulatory, respiratory, and musculoskeletal problems. Whether through decubitus ulcers, urinary tract infections, circulatory impairment that results in foot problems and vision loss, or through pulmonary disease that assaults those with compromised lung status, day after day people with disabilities are confronted with life-threatening, but preventable, problems.

The pressure sores that present a major health risk for people who have spinal cord injuries can often be prevented through factors like regularly received health care, properly designed seating, personal hygiene, and prompt treatment. Remediable genitourinary tract disorders that are problems for people whose major motor function is severely restricted, can be stopped with rapid intervention and prophylaxis. Nutritional disorders, alcohol and drug abuse, inadequate personal hygiene, and acute and chronic illness, all present themselves more frequently in people with disabilities.

HEALTHY PEOPLE OBJECTIVES FOR PEOPLE WITH DISABILITIES

Concurrent with the development of the year 2000 objectives in the late 1980s, our office funded a study that analyzed the health promotion and disease prevention goals of that decade and how fully they had encompassed primary and secondary disability prevention. The study was largely conceived by Michael Marge and the National Center on the Handicapped. The report produced by the analysis suggested that in the 1990s consideration be given to expanding certain objectives related to disability prevention or intervention. Preventive service objectives were recommended in the areas of high blood pressure control, pregnancy and infant health, and sexually transmitted diseases. Health protection areas to be targeted involved toxic agents and radiation control and occupational safety and health. New objectives were recommended in the areas of vision and hearing disorders, improvement of mental health, learning disabilities, and maintaining function in older adults.

This report, as one of the first components in the development of a national plan on prevention of disabilities in America, was well received and has been helpful in developing policy. Another vital part of the process was developing data to track factors such as incidence and prevalence of disabilities. We also have established the Interagency Committee on Disability Statistics, a committee including the Public Health Service and others, that meets on a regular basis to discuss disability issues including data.

The year 2000 objectives include 19 items that are directly related to improving health status, reducing risk, or improving service delivery for people with disabilities. They seek to:

- increase the proportion of people with disabilities who engage in regular leisure time physical activity (objective 1.5). (In 1991, 30 percent reportedly had *no* leisure time physical activity.)
- reduce overweight to a prevalence of no more than 25 percent among people with disabilities (objective 2.3). (In 1985, 36 percent of people with disabilities were overweight.)
- reduce to less than 40 percent the proportion of adults with disabilities who have experienced adverse health effects from stress within the past year (objective 6.5). (In 1985, 54 percent reported problems related to stress.)
- increase the availability of community support programs for adults with severe, persistent mental disorders (objective 6.6). (In 1986, only 15 percent used such programs.)
- increase to 45 percent the proportion of people with major depressive disorders who obtain treatment (objective 6.7). (In 1983, only 36 percent of such people were in treatment, and we have no more recent data.)
- increase to at least 30 percent the proportion of adults with disabilities who

seek help in coping with personal and emotional problems (objective 6.8). (In 1990, 17 percent sought help, up from 15 percent in 1985.)

- achieve access to high quality and developmentally appropriate preschool programs to help prepare for school all disadvantaged children and children with disabilities (objective 8.3). (A proxy measure of this goal showed that 56 percent of eligible children aged 4 were afforded the opportunity to enroll in Head Start in 1991.)
- reduce the incidence of secondary disabilities associated with head and spinal cord injuries to no more than 16 and 2.6 per 100,000, respectively, by the year 2000 (objective 9.11). (In 1986, the rates were 20 and 3.2 per 100,000, respectively, for these two conditions. We have no more recent data for this objective.)
- minimize trauma deaths and long-term disability, and extend to all states emergency medical services and trauma systems that link prehospital, hospital, and rehabilitation services (objective 9.22). (In 1989, only two states had such linkages.)
- increase to at least 95 percent the proportion of newborns screened for genetic disorders and other disabling conditions, and to 90 percent the proportion of newborns testing positive for disease who receive appropriate treatment (objective 14.15). (Our data show good progress in this area of screening and treatment for galactosemia or sickle cell.)
- reduce the proportion of older adults who have difficulty in performing two or more personal care activities to less than 90 per 1,000 for those aged 65 and above, and to less than 325 per 1,000 for those aged 85 and above (objective 17.3). (1984–85 baseline data was 77 per 1,000 for those aged 65 and above, and by 1991 this had declined to 51 per 1,000. For those 85 and older this data was 223 and 151 per 1,000. Note that because of data revisions, the year 2000 targets are actually higher than the baseline. This is good news. Between 1987 and 1991, the proportion of those with problems had declined by about 30 percent for both age groups.)
- increase the proportion of worksites that have an established program for hiring people with disabilities (objective 17.19). (In 1989, only 37 percent of medium and large companies had such programs.)
- increase to all states a service system for children with, or at risk of, chronic and disabling conditions (objective 17.20). (No baseline data are available.)
- increase to 80 percent the proportion of people with disabilities who receive recommended clinical preventive services—including screening, immunizations, counseling (objective 21.2). (In 1991, only 12 percent of disabled adults had received these services.)

CURRENT PROGRESS

Progress toward these targets is mixed, but our challenges are clearly identified. The key is action. Another key component is the need for data by which progress can be monitored. From the federal perspective, activity exists not only within the Public Health Service, but with our other federal partners as well. Some of the prominent agencies we work closely with include the Department of Agriculture on nutrition objectives, the Environmental Protection Agency on environmental health objectives, and the Department of Transportation on motor vehicle injury-related objectives. These interactions across the federal government, and in conjunction with state and community health officials, help us to review strategies and barriers to achieving the objectives.

Government alone cannot meet these objectives. Our leadership and involvement is a necessary, but not a sufficient condition for progress. Changes need to take place throughout America's homes, classrooms, clinics, and worksites if the objectives are to be achieved. Consequently, we have sought the commitment of more than 375 national membership private and voluntary sector organizations, obtaining pledges to help implement the nation's prevention agenda through our *Healthy People 2000* consortium. Among the groups that have a particular interest in health promotion activities for the disabled population are the National Mental Health Association, the Learning Disabilities Association of America, the General Federation of Women's Clubs, and the Arc. Each year, we have a meeting to exchange ideas and renew acquaintances—within the private sector and with individuals representing local, state, and federal government. This year's consortium meeting is scheduled for October 28th.

MIDCOURSE REVISIONS

As the midpoint of the decade approaches, the Public Health Service is reviewing the year 2000 objectives. The review is based primarily on three principles: 1) year 2000 target revisions are necessitated by changes to baseline data; 2) new special population subobjectives are needed where data are now available that indicate increased risk for subgroups; 3) modifications are needed to address new science or program gaps.

Because there are now 38 states and the District of Columbia that have published their own year 2000 objectives, and there are many private and voluntary organizations with initiatives based on the objectives, we are viewing this process as a review and refinement. This fall, there will be a public review and comment period as part of our revisions process, and we would welcome your input at that time.

CONCLUSION

We have the ability to prevent premature loss of life and enhance health outcomes for many individuals. Implementation of what is already known about promoting health and preventing disease is a central challenge of *Healthy People 2000*. *Healthy People 2000* also poses a fundamental challenge to the nation to move beyond saving lives toward improving the quality of life. This will require the combined strength of scientific knowledge, professional skill, individual commitment, community support, and political will to enable all people to achieve their potential to live full, maximally functional, and satisfying lives. The health of the nation is measured not by how long the oldest person lives, but by the extent to which gains are accomplished for all people. Thank you for your leadership in moving us toward this goal, and thank you for the opportunity to be here with you today. ▩

Implementing Programs for Disability Prevention

Andrew Imparato, Esq.
Counsel, Senate Subcommittee on Disability Policy
Hon. Tom Harkin, Chairman

I AM PLEASED to be here on behalf of Senator Tom Harkin, who has been leading an effort over the past several years to expand federal support for programs to prevent disabilities and eliminate or reduce functional limitations associated with having a disability.

As counsel to the Senate Subcommittee on Disability Policy, chaired by Senator Harkin, I have worked on prevention of secondary disabilities in the context of health care reform. I am speaking today in place of Peter Reinecke, Senator Harkin's legislative director and formerly his legislative assistant for health issues, who has worked closely with Dr. Marge and others on a broad range of prevention issues for Senator Harkin. I am grateful to the American Disability Prevention and Wellness Association for convening this important conference and for inviting our participation, and I am particularly grateful for the opportunity to learn about the private sector's role in prevention.

> *"Although our health care reform efforts are not likely to pay off this year, there is clearly a congressional interest in refocusing our health care system on methods that promote health and prevent primary and secondary conditions and disabilities."*

As chair of the Appropriations Subcommittee that funds HHS, Education, and Labor, Senator Harkin has initiated funding for disability prevention programs at the Centers for Disease Control and Prevention (the "and Prevention" was added as a result of legislation sponsored by Senator Harkin).

Some examples of prevention programs for which Senator Harkin has provided funding

increases, or which have been initiated since Senator Harkin became chair of the Appropriations Subcommittee, include:

- a national birth defects registry;
- fetal alcohol syndrome prevention centers;
- comprehensive school health programs that include prevention components;
- a mental retardation project looking at the connection between better nutrition and preventing mental retardation;
- spina bifida prevention programs.

The Subcommittee has also funded domestic violence prevention programs, farm health and safety initiatives with a focus on preventing disabilities for adults and children, and smoking cessation initiatives.

There is a growing acknowledgment on the Hill that there needs to be a national effort in this area, and that acknowledgment is reflected in the prevention focus of the major health care reform proposals. There is an increasing recognition of the importance of shifting our focus from a "sick care system," as Senator Harkin calls it, to a health care system that explores the root causes of health conditions and works to promote health and maximize individual functional potential.

In the course of our debate on health reform this year, we made a number of changes at the committee level and on the floor that were geared toward both primary and secondary prevention. These included:

- an amendment from Senator Dodd on the floor that would have phased in more quickly the requirements for health plans to cover clinical preventive services and prenatal care services with no copayments or deductibles;
- in the Committee on Labor and Human Resources, we included language giving incentives to initiate workplace wellness and smoking cessation programs;
- outpatient rehabilitation services were defined in the Labor Committee to clarify that prevention of deterioration in functioning and minimization of functional limitations are proper goals of such services;
- the Labor Committee bill added a new program of extended services for children with special health care needs as part of a new home and community-based long-term care program, in recognition, in part, of the preventive value of comprehensive services for children.

Although our health care reform efforts are not likely to pay off this year, there is clearly a congressional interest in refocusing our health care system on methods that promote health and prevent primary and secondary conditions and disabilities.

I will close by encouraging all of you, as prevention advocates, to keep two things in mind as you move forward with a public prevention agenda in the coming months and years.

First, particularly in the deficit reduction atmosphere that is only likely to be stronger in the next Congress, it is essential that we be able to document the cost-effectiveness of preventive services. Historically, the Congressional Budget Office has refused to score savings from prevention. This is an oversight that must be addressed if we are to come up with the funding for a proactive prevention agenda.

Second, it is essential that disability prevention advocacy, like disability advocacy in general, remain bipartisan. Clearly, there are strong supporters of prevention in both parties, and there is no reason why this issue should be played out in partisan ways.

At the markup of the health bill in the Labor Committee, Senator Strom Thurmond went immediately before Senator Harkin in making his opening statement, and he spent the majority of it talking about the importance of a greater emphasis on prevention in our health system. Senator Harkin began his remarks by saying that he agreed with three quarters of what Senator Thurmond had said. It is the job of all of you, as prevention advocates, to capitalize upon this bipartisan agreement to foster a national consensus about the importance of prevention, and to increase public and private investment in prevention that encompasses both primary prevention and the prevention of secondary conditions. ■

People with Disabilities: We Can Be Well

Sunny Roller, M.A.
Coordinator, UMMC Diversity Program
University of Michigan

PEOPLE WITH DISABILITIES can be well. We can reach advanced states of psychological, spiritual, and physical health. A wellness lifestyle is a positive, deliberate, and proactive approach to achieving and maintaining a sense of harmony and pleasant satisfaction with who we are and the life we are living. We can take control of our lives; we can have a feeling of purpose and belonging; and we can feel a basic satisfaction with ourselves and our existence: intellect, body, and spirit. We can be well.

The prevention of new disabling conditions is part of this wellness model. It says, let's take control of our health before it's too late. Its basic premise is that we are valuable human beings who deserve to be as fully functioning as possible.

Since the age of four, I've been moving through life as you see me—using braces, crutches, and sometimes a wheelchair. My life with a disability has been very productive. Lately I've been wondering what lies down the road for me. What will happen to my health in five years? In ten years? I know that my disability can complicate my ability to stay healthy and that I must be vigilant about taking care of myself. I would not choose to have a new disease on top of my polio right now—no diabetes or heart disease if I can help it. I do not wish for greater pain, fatigue, or weakness, nor do I wish for a secondary disability. I am a respectable, loving, worthwhile person with my current disability, and will remain a good person no matter what happens to me, but I do not want to lose function in my arms or legs or wherever,

> "*We are part of the new prevention movement in our country that proclaims it is kinder and much more astute to ward off disease and disability* before *they occur.*"

if that can be controlled and prevented.

I believe that the prevention of secondary conditions is important and that with a well-informed, well-developed vision, sound preventive care is possible. We, in this room, are the visionaries. We are part of the new prevention movement in our country that proclaims it is kinder and much more astute to ward off disease and disability *before* they occur. We are positively focused on health and wellness care with the hope that we can eliminate the need for so much sickness and crisis care. We are shifting our paradigm to focus on long-range health outcomes and the financial benefits of staying well. We have the skills and the resources to help people focus on wellness but we need to begin to ask the right research questions, to use our scientific skills to find out what prevents and who is at risk. We also need to become educators in our culture about the value of prevention, because many people just don't see it.

I believe this is true for my colleagues in the U.S. who have disabilities. Many of us are not taking care of ourselves the way we should. We aren't going to primary care physicians for regular checkups because we can't get into their offices or onto their examining tables. Or, if we can get into their offices, we need a longer time to explain how our disability affects our health and to develop an informed working relationship with our doctors. We often have to challenge and expand our physician's knowledge base, and that can be tiring and threatening for both of us. We are disincentives for our doctors because we cost them money and time—we inhibit the daily patient quota plans our doctors are asked to achieve. I asked my doctor 15 years ago if there was anything I could do proactively to prevent breakdown. She said, "No." Did that mean "No" or "I never thought about that possibility?" Our culture does not support our need and desire to stay physically fit. It's tough to fit in with the gang at Vic Tanny or find an accessible swimming pool. Weight loss centers don't quite know what to tell us or have the right scales to weigh us. So we think, "Why bother?" It's such a burnout to battle the building and the psychological brick walls. Who needs to go through all that to stay healthy and happy when these disincentives all around us repeat in our ear with an underhanded monotone, "You're not really worth it. Your wellness is not important. You are part of a limited subgroup in our culture that is best ignored."

But I say, just as we have changed our attitudes about smoking in the U.S., and shopping at Wal-Mart in our wheelchairs, we can change our attitudes about wellness and good preventive health care for people with disabilities. We can educate through media campaigns about the value of getting checkups. We can show people with disabilities going to their doctors' offices or waiting in line at the health-o-ramas along with everyone else. We can enforce ADA requirements, and create opportunities, and show people with disabilities participating in exercise programs

or healthy eating programs either with or next door to our non-disabled neighbors. The message will say to each of us, "You are valued and we want you with us a little longer." I think insurance companies need to support people's health promotion behaviors and provide incentives to everyone for staying well.

We may not be ready to copy the European spa system where state insurance pays for people with disabilities to check into a spa for six weeks each year to rejuvenate and strengthen, but we can create feasible opportunities for people with disabilities to stay well. The message needs to go out. It can be done.

We can be well. The consumer needs to hear that. We need to know that wellness is doable. Thank goodness we are here today as agents for change—each contributing new ideas to create that vision. ▩

The Private Sector's Role: Preventing Disabling Conditions

Susan Olson, M.S.P.H.
Manager, Medical Division
Administrative Services and Health Promotion
UNUM of America Insurance Company

WHAT IS THE PRIVATE sector's role in preventing disabling conditions among its employees? First, why should the private sector care about prevention? We know that billions of dollars are spent annually in this country on diseases and conditions that are largely preventable, like heart disease, cancer, and injuries. We have heard much this year about the health care crisis in the United States and we have heard many ideas about how to fix it. In 1993, 14.7 percent of our Gross National Product was spent on health care. Health insurance today is largely organized and financed through the workplace. In 1993, *Business Week* estimated that employers would pay 51.7 percent of the national health care bill. In addition to the direct costs of medical treatment, indirect costs include absenteeism, lost productivity, workers' compensation, long- and short-term disability, recruitment and retention costs, and reductions in work quantity and quality.

> *"A worksite is an ideal place to promote the health and well-being of adults and their dependents. It is the place where working adults spend most of their time. Healthy people equal a healthy business—this is a fundamental principle of business success in the 21st century."*

Why should the private sector care about preventing disability and promoting the health and well-being of its employees, retirees, and their dependents? The bottom line is that businesses pay much of the cost of poor health and disability in one way or another. On a more human level, because employees are the core of

a business, they are valuable and not easily replaced. Employees also have families and friends who need them.

A worksite is an ideal place to promote the health and well-being of adults and their dependents. It is the place where working adults spend most of their time. Healthy people equal a healthy business—this is a fundamental principle of business success in the 21st century.

I will spend a few minutes today talking about *how* the private sector can prevent disability and promote health—in general terms. I will also give an overview of UNUM's efforts to create a work environment that enhances the health of employees, retirees, and their dependents.

PREVENTING DISABILITY: OCCUPATIONAL HEALTH AND SAFETY

One important way the private sector can prevent disability is to create a safe workplace by following OSHA regulations, developing work processes that prevent rather than produce injuries, providing case management for disabled employees, encouraging employees to return to work, and making accommodations in the work process to allow a disabled employee to effectively work within any restrictions or limitations.

The private sector also must make sure that formal company policy is not contradicted by corporate norms or implicit messages. For example, truckers working long hours without sleep and causing serious injury to themselves or others as a result; desk workers who have ergonomically correct work stations but work long hours keyboarding without a break and get repetitive use injury; providing lifting training but not setting up storage areas to promote proper technique; taking risks with hazardous chemicals because it's faster or cheaper, etc. We must "walk the talk."

By law, employers need to do most of this, but one cannot talk about health promotion and other programs without being clear that worksite safety is an essential component of good health and disability prevention.

WORKSITE HEALTH PROMOTION

Worksite health promotion is part of an overall benefits and risk management strategy that the private sector can use to manage health care costs and prevent disability. Health promotion is not *the* cost containment strategy, it is an important part of a mix of strategies that businesses can use to reduce the demand for, and cost of, health care. Health promotion is also a potent factor contributing to enhancement of a company's human capital. Emphasizing self-responsibility, balance, and taking action, wellness programs enhance organizational efforts designed to improve teamwork, innovation, quality, and creative thinking.

Comprehensive health promotion programs offer a variety of health education opportunities (based on demographics, corporate culture, medical and disability claims, and EAP experience in the worksite), policy (such as no smoking, work/home balance, alternative work, diversity), health screening opportunities, exercise programs, and other recreational activities. Often, programs are offered to retirees and family members, because a large part of the health care bill is affected by dependent care. A good worksite health promotion program will work in tandem with any Occupational Health and Safety initiatives, Human Resources, and any medical department to provide effective programming to employees, retirees, and their dependents. These programs must pay attention to goal setting, developing programs *with* management support and employee involvement, and evaluation.

Before I discuss the programs at UNUM, I want to spend a moment on the cost-effectiveness studies that have been done on health promotion. It should come as no surprise that several studies have demonstrated that the cost for "high risk" employees (those who smoke, are sedentary, have high blood pressure and cholesterol, for example) drive up the costs of health care. It has been estimated that 10 percent of the employees account for over 58 percent of the total medical claims costs in a seven-year period.

There is a wealth of evidence to support the wisdom of *preventing* an injury or disease before it occurs. We know that the proper use of seat belts can prevent 40 to 60 percent of motor vehicle injuries and deaths, that exercising reduces medical care and sick care costs, that 75 percent of the compensation costs of low-back injury are attributable to the 7.4 percent of the patients who stay out of work more than six months. We also know that cigarette smoking is the single most important preventable environmental factor contributing to illness, disability, and death in the United States, and that reducing cholesterol and maintaining healthy blood pressure and weight will reduce the risk of heart disease.

Edington, of the University of Michigan Fitness Research Center, has estimated that if it were possible to control all modifiable risk factors, the risk of cardiovascular disease would be reduced by 43 percent, cancer by 23 percent, and diabetes by 50 percent. These changes could result in as many as 40 percent fewer premature deaths, and as much as a 33 percent decrease in acute disabilities, and a 66 percent decrease in chronic suffering. After a review of over 1,500 studies on the impact of health promotion, Edington estimated that the benefit-to-cost ratio for health promotion is $2.50 for every dollar invested, over a seven-year period. The benefits include savings in absenteeism, productivity, and health care costs. And this figure is conservative (the range being $2.50 from DuPont to $6.10 from Coors).

Because high-risk behaviors are not distributed equally across different companies, the focus of worksite health promotion efforts varies across businesses.

The type of business you are in also affects the efforts needed for occupational health and safety. Finally, disability claims, employee benefit, and workers compensation costs increase as workplace stress increases. Common causes of workplace stress include management change, layoffs (rumored or actual), long work hours for extended periods of time, personal conflicts, unrealistic deadlines, and limited advancement opportunities. Preventing disability and enhancing employee/dependent health must take these issues into consideration. Health promotion programs are just one way to manage disability and enhance the health of employees.

UNUM'S EFFORTS

UNUM of America is based in Portland, Maine, with over 3,500 employees at its headquarters and another 1,200 in field offices across the continental United States and in Canada. UNUM is the leading provider of disability insurance products and services in the United States and the United Kingdom and a major provider of long-term care and retirement products.

UNUM's employee population is 70 percent female, the average age is 35, and the work done at UNUM is primarily desk work using computers, telephones, and other office technology. The top six medical claims at UNUM are related to:

- pregnancy
- newborn care
- musculoskeletal problems
- circulatory problems
- female reproductive system
- respiratory system

The top three categories of *short*-term disability claims (aside from pregnancy) are mental/nervous, back and shoulder injuries. The top three categories of *long*-term disability claims are similar: mental/nervous, muscular-skeletal, and back.

UNUM prevents disability and manages medical care and workers' compensation and disability costs through a combination of insurance plan design, case management, human resource policy, working to create a good corporate culture, an employee assistance program, Occupational Health and Safety programming, and the health promotion program (Wellpower).

Insurance Plan Design

UNUM's medical plans (both general medical and HMO) provide employees and their dependents with preventive health care, including prenatal care and newborn care, immunizations, and preventive tests ordered in conjunction with an annual exam (up to $200 per calendar year), screening programs (including mammography),

and regular physicals. The medical plan encourages seat belt use by waiving the deductible and coinsurance if you are in a motor vehicle accident while wearing a seatbelt.

UNUM's short-term disability program allows employees to accrue up to two weeks of 100 percent sick time pay every year. Once the accumulated sick time pay is used, employees go to 70 percent pay until their short-term disability is over or long-term disability starts. Long-term disability plans go into effect after an employee has been out on disability for 180 days. At this point, the plan pays 60 percent of salary. UNUM coordinates this program with Occupational Health and Safety, workers' compensation, and social security authorities. UNUM aggressively case manages disability to encourage employees to return to work and to encourage managers to make accommodations that allow employees with restrictions or limitation to do their job.

As a result of plan design changes, aggressive case management, occupational health and safety, and health promotion, the incidence rate of long-term disability had decreased significantly. Premium rates were reduced by 15 percent four years ago and 10 percent the following year. They have remained flat since then.

Occupational Health and Safety

UNUM's Occupational Health and Safety program is responsible for complying with all OSHA requirements, ensuring a safe work environment, and managing workers' compensation cases. It runs an Occupational Health Clinic and encourages prevention through ergonomically correct work station design, VDT education, classes in back lifting and hazardous communication, and safety teams. The Occupational Health and Safety program works collaboratively with Human Resources and UNUM's health promotion program, Wellpower, to prevent and manage work-related injuries. UNUM's experience modifier is a very low 0.67 with an OSHA standard for our business set at 1.00.

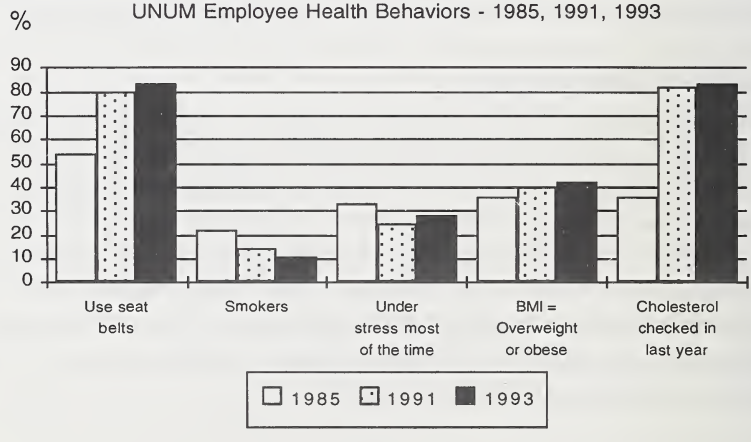
Health Promotion

UNUM has offered employees, retirees, and dependents its award-winning health promotion program, Wellpower, since 1985. Wellpower offers a wide range of programs based on employee surveys, demographics, medical and disability experience, EAP trends, and an employee health promotion committee. Wellpower includes:

- a 10,000 sq. ft. ***fitness facility***, offering 23 pieces of cardiovascular equipment, weight training, and 32 exercise classes per week;
- ***stress management education*** in parenting, financial planning, time management, communication, and team building;

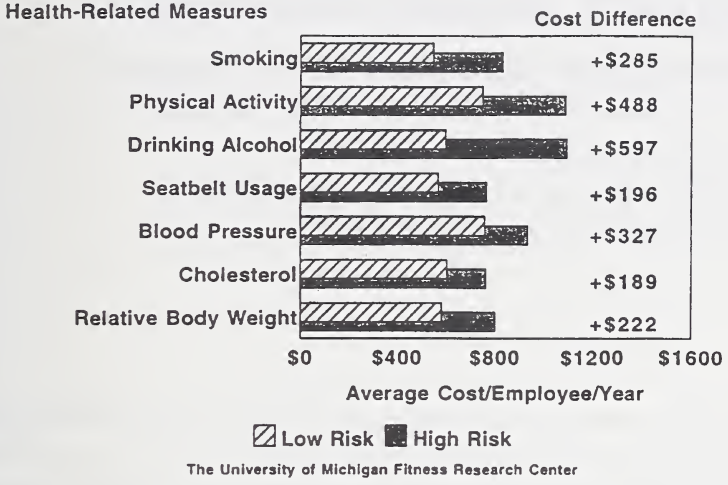
- ***self-care programming*** in CPR, first aid, self-defense, baby care, car seat, and women's health education;
- ***weight management and nutrition programs;***
- ***screening programs*** for blood pressure and cholesterol;
- intramural ***sports and recreation;***
- corporate ***track team;***
- ***reimbursement;***
- video and printed ***resources, health information;***
- ***United Way referrals.***

Since the inception of the Wellpower program there have been significant changes in employees' health behaviors, including significant increases in seat belt use and cholesterol screening participation, and a significant decrease in smoking. Reported stress levels have stayed flat (despite reengineering, demutualization, and other corporate changes) and weight levels have not changed significantly while exercise levels have remained steady (although the average age of employees has increased).

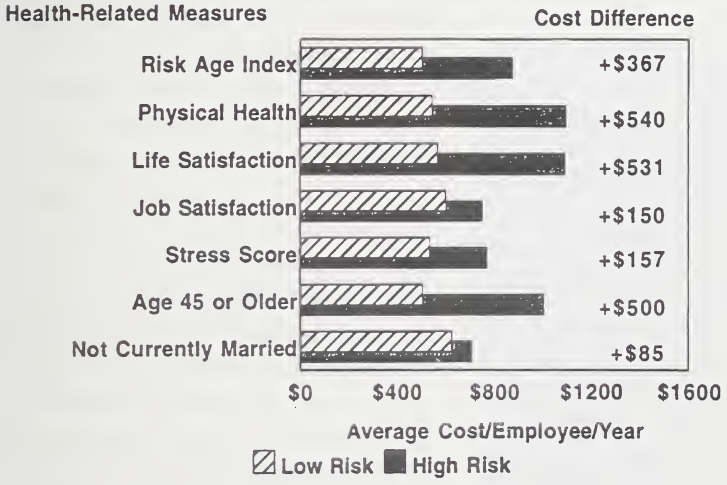


We have compared UNUM trends with those in the state of Maine and with national data. The trends for UNUM show change that is different from, and better than, state and national data. Thanks to an aggressive marketing campaign, over 50 percent of UNUM employees participate in the Wellpower program, and a growing number of dependents and retirees are also participating. ▩

Medical Claims Costs by Health Risk Levels



Medical Claims Costs by Health Risk Levels



Comments on Disability Prevention: Perspective of Business and Industry

Kathy Kirchner, Director
Institute for Rehabilitation and Disability Management
Washington Business Group on Health

THE PROBLEM OF disability in the workplace has become a central concern for business as the economic and human costs grow exponentially each year. The extensive personal losses associated with disability and resulting unemployment and the staggering economic cost of disability in income maintenance, health care, and lost productivity are of critical importance. Consider these statistics:

In 1991, the Centers for Disease Control estimated that seven in every 100 workers sustain a nonfatal work injury in a given year.

- In 1989, nearly 2 million workers sustained injuries that resulted in disabilities. At that time the cost of accidents occurring on work time was estimated at $83 billion and resulted in 2.9 million lost workday cases.
- Annually, nearly 11 million people are injured while working. These injuries include 11,600 deaths and 2.3 million disabling injuries.
- The average worker sustains more injuries off the job than while working. Annually, there are 42.9 lost workday injuries at work per 1,000 workers. Off the job there are 49.6 lost workdays per 1000 people aged 15 to 64.
- On average, injuries cost employers $1,700 per benefit-eligible employee. Injuries are responsible for 29 percent of total fringe benefit costs related to illness

> *"Company disability prevention and management initiatives have been shown to be associated with performance improvements."*

or injury, 19 percent of employers' health costs, and 46 percent of employers' sick leave and disability payments.

- Total disability costs comprise more than 8 percent of payroll dollars.

Employers recognize the human and economic costs of effective disability management and prevention. Recent research has demonstrated that effective disability prevention strategies include the following factors:

1. ***People-Oriented Culture*** including concern about retaining and developing personnel, high job satisfaction, a high level of trust and cooperation within the company.
2. ***Active Safety Leadership*** including top management support and active and aggressive safety management programs.
3. ***Safety Diligence*** including the identification of hazards and quick supervisory responses.
4. ***Wellness Orientation*** including health promotion and wellness programs.
5. ***Ergonomic Solutions*** including job modification, position rotation, improved workstation and product design.
6. ***Safety Training*** of all regular, temporary, and new employees required prior to undertaking duties.

Company disability prevention and management initiatives have been shown to be associated with performance improvements. We know that workplace disability can be prevented. We know that the strategies are not magical. They are common sense. But they occur too infrequently for the millions of American workers affected each year. And there is considerable variability in the workplace disability experience of employers. This conference is an important effort in recognizing the importance of preventing disabling conditions. In tandem with the ADA, disability prevention and accommodation can keep America working. ■

Comments on Disability Prevention: Consumer's Perspective

Christy Gilliland
Advocate for Persons with Disabilities and Consumer

AS I LISTENED TO Larry Burt, Dr. Jackson, and Dr. McGinnis speak, I realized that to meet *Healthy People 2000* objectives, especially those that deal with prevention, people with disabilities must become involved with these efforts. We must realize that we hold our future in our own hands. We cannot continue to depend on others to improve the quality of our lives. Only by empowering ourselves to take control of our lives, will we reach our goals. People with disabilities who are integrated into the community, working and being active in their communities, must begin to educate others—other people with disabilities, their families, and the public in general—on the importance of controlling their own health care. It is imperative that we take the lead role in preventing disabilities, especially in preventing secondary conditions. We know our own bodies and our own minds better than anyone else. We must begin to realize how important our health care is and start taking better care of ourselves. This is how we will begin the prevention of such secondary conditions as decubitus ulcers, urinary tract infections, alcoholism, drug abuse, and depression.

> *"Unfortunately, in this society there are still doctors' offices, clinics, and health spas that are inaccessible to many people. Without assistance from communities and the private sector, the barriers will remain. People with disabilities must be allowed the same health care benefits as everyone else."*

This is not to say that all people with

disabilities have the means to treat themselves. Unfortunately, in this society there are still doctors' offices, clinics, and health spas that are inaccessible to many people. Without assistance from communities and the private sector, the barriers will remain. People with disabilities must be allowed the same health care benefits as everyone else. YMCAs and other health spas should provide equipment that is accessible to all people. People with disabilities should have the freedom to be involved in all sports activities.

We control our own destiny. It is time that people with disabilities realize that we are the leaders in prevention and health care for ourselves. We must take charge of our health, and not depend on others to do it for us. ▩

Health Promotion and Wellness for Persons with Disabilities

Fred R. Patterson
Management Consultant
Office of Corporate Contributions
Johnson & Johnson

JOHNSON & JOHNSON'S health promotion program Live For Life has cut employee hospital cost increases nearly in half at participating facilities, compared to facilities without the program.

The free, on-site Live For Life health promotion program includes health screening and lifestyle improvement programs, including smoking cessation, weight reduction and control, blood pressure and cholesterol monitoring, stress management, and nutrition education. It also incorporates changes in the workplace to support healthier lifestyles.

In a study covering 11,406 Johnson & Johnson employees in 18 states over five years, Live For Life participants' hospital cost increases averaged $42 per year versus non Live For Life participants who had increases averaging $76. Hospital admissions and hospital days per employee also increased at a significantly lower rate for employees in the Live For Life program than for the control group:

- While 17 of every 1,000 employees in the control group, on average, were admitted for hospital stays, only 8.6 Live For Life participants per 1,000 were admitted.
- Hospital days increased by 109 per 1,000 for employees in the control group, but hospital days increased by only 67.5 per 1,000 for Live For Life participants.

> *"...companies with intensive health promotion programs can realize major savings in health care costs when there is a high employee participation rate over several years."*

This study and others clearly demonstrate that companies with intensive health promotion programs can realize major savings in health care costs when there is a high employee participation rate over several years. In this study, researchers projected a health promotion-related annual savings averaging $245,000, or nearly $1 million over the full study period. They called this "a conservative estimate of inpatient cost benefits." The Johnson & Johnson Live For Life program has cut hospital cost increases for employees nearly in half. This is of critical importance because hospital costs account for up to two-thirds of a company's total health benefit costs.

In short, Johnson & Johnson has proven that prevention pays. The program has now been expanded to spouses, retirees, and to preschool children in the corporation's child development centers. And it has been a particular blessing for employees with disabling conditions. Employers implementing an on-site employee health promotion program can realize savings in line with the following figures from Johnson & Johnson:

Savings per Employee (4th year)	
Inpatient health care costs	$223
Reduced absenteeism (3rd year)	156
Gross Savings per Employee	**$379**
Subtract per employee cost of providing health promotion program (1990s dollars)	($225)
Net Savings per Employee	**$154.00**

Employer-sponsored health promotion programs are effective in three ways:

- controlling health care cost increases;
- improving overall employee health levels;
- improving employee morale and productivity.

The most successful health promotion programs are those that:

- achieve and sustain high employee participation;
- provide management information for program direction.

In January 1987, Johnson & Johnson announced the creation of Johnson & Johnson Health Management, Inc., a wholly-owned subsidiary, to market a comprehensive line of health promotion programs and services. This subsidiary aims at the heart of one of the nation's most serious business problems, the escalating cost of employee medical care. It offers consultations, health assessments, health improvement programs, motivation and promotion programs, training and administrative systems, and management information.

The credo at Johnson & Johnson has long recognized the social responsibilities the corporation has to the community. Our corporate office of contributions donates

$52 million each year, primarily to maternal and child health initiatives. I would like to share with you some of the exciting initiatives that relate to the issues being discussed at this conference.

Johnson & Johnson School Nurse Training Program

For several years, school nurses have attended a Johnson & Johnson substance abuse program held at Rutgers University each summer. They receive training on how best to implement education in this critical area within their schools. This program has received very high praise from participants.

Fetal Alcohol Syndrome

Working with high school students, Johnson & Johnson developed an interactive computer media program that teaches students about fetal alcohol syndrome, its prevention, and available community resources. This program is available statewide at no charge.

Women's Health Issues

Women's health issues are one of the major concerns of the day, and we must not forget the health needs of women with developmental disabilities. On September 23, Johnson & Johnson will announce the release of a half-hour video entitled "Let's Talk About the Health of Women with Developmental Disabilities," along with a teaching guide. This project was developed by the Arc/NJ under a corporate grant. The video is narrated by Jane Hanson of WNBC-NYC, filmed at Robert Wood Johnson University Hospital, and stars women with developmental disabilities. It covers breast self-examination and many other women's health issues. The targeted audience is women with developmental disabilities, and to that end Johnson & Johnson is donating a copy of the video to all 400 group homes in New Jersey and to more than 100 hospitals. On October 27th at the Arc/US National Convention, Johnson & Johnson will announce the national availability of this program.

Lead Poisoning

Before the year is out, Johnson & Johnson will launch a New Jersey Lead Poisoning Prevention Education plan that will place great emphasis on pre/post testing to measure factors changing behavior. The plan will target parents and their children from conception through age five. Primary emphasis will be placed with Head Start children in Jersey City and Paterson, New Jersey.

National Safe Kids Campaign

Many of you are aware of Johnson & Johnson's founding of this campaign to prevent

unintentional injuries to children under age 14. Each year, Johnson & Johnson contributes $1 million to Children's National Medical Center here in Washington, DC. The program is in its eighth year.

The New Jersey Safe Kids Coalition, under Johnson & Johnson sponsorship, was instrumental in educating the state legislature as to the critical need for a children's mandatory bike helmet law to prevent head injuries. Thus, New Jersey became the first state to pass such a comprehensive law. Eight states have followed, meaning that one third of our nation's children are covered. Helmet usage has risen from under 5 percent to 68 percent, and the Level I New Jersey trauma centers report a 60 percent decline in hospital admission rates for bicycle accidents in the first year after the law's passage. ■

Opportunities for the Private Sector in Preventing Disabling Conditions

Dean Witherspoon
President, Health Enhancement Services

THERE ARE MANY opportunities for the private sector in preventing disabling conditions. All that is needed, quite often, is an adjustment in attitude. If educators, supervisors, and management can adjust their attitudes, it will be easier for them to get workers to adjust theirs. The results can include increased productivity and profitability, as well as increased satisfaction all around. First, we need to think in terms of opportunities—not in terms of obstacles. A few points will illustrate what I mean:

- Disability prevention is an opportunity for business and industry.
- Prevention contributes directly to the bottom line and boosts profits.
- Prevention initiatives boost morale and convince workers that an employer cares about a worker's whole life, not just their contribution to profits.

Clearly, in the competitive environment of today's—and tomorrow's—business world, the successful employer will be the employer who invests in measures to promote worker's health and satisfaction. This includes making efforts to prevent worker's disabilities. Stories are told in every industry of businesses losing out to their competitors because they failed to wisely invest money or time in work process improvements. The process of preventing disabilities is no different from any other process improvement; if efforts are made to avoid a problem before it

> *"By supporting, rewarding, and reinforcing healthy lifestyles, individual risk reduction, and self-responsibility, business and industry can stem the rise in illness and injury while maintaining healthy profits."*

occurs, long-run profitability and satisfaction of both worker and employer will increase.

We must face the fact that disabling conditions are prevalent throughout industry. Traditionally, manufacturing/blue collar industries have experienced high rates of worksite injuries. This serious problem remains, and there does not appear to be significant improvement on the horizon as workers continue to be pushed to do more, in less time, with fewer resources. Cumulative trauma in the office is expected to continue to increase rapidly as more jobs become tied to computers and workers have less variety in their activities. As tasks become more specialized, repetitive trauma is becoming the primary affliction of the information age.

There has been a tremendous rise in reported repetitive syndrome injuries (RSI) and we know that some of this rise is due to improved reporting procedures. But aside from better reporting, there has been, undoubtedly, a real rise, and this presents a growing problem for business and industry. As the number of RSIs increases, there is concern that these injuries are spread by mouth, i.e., when workers learn of a coworker's affliction, they develop similar symptoms. Given human nature, this phenomenon will likely continue. When attitudes are adjusted and organizations begin to see prevention as an opportunity to reduce costs, improve efficiency, and enhance work life, the trend may begin to reverse itself.

Approximately four years ago, the Dow Chemical Company's Texas operations adopted a new paradigm and began to see back injuries as an opportunity. Faced with rising injury statistics that translated into escalating costs, and believing that reversing the trend would require a multifaceted solution, Dow Chemical designed a comprehensive strategy to address back sprains and strains. The strategy consisted of two phases: Backs in Action (a 3-hour education component) and Ready for Work Warm-Ups (an ongoing stretch and flex program for workers). The results far exceeded everyone's expectations.

Whether it's repetitive trauma or other chronic illness, companies have tremendous opportunity to affect behavior through community programs and organizations. Through funding, partnerships, pooled resources, and creative initiatives, communities can benefit greatly from the synergy and strength of collaborating organizations.

Two excellent places to start are chambers of commerce and school systems. Chambers of commerce first, because they exist to support business and industry in their communities. Since disabling conditions cut across organizational and industry boundaries, initiatives in this area are likely to receive broad support. Schools are prime resources because children's activities at school have tremendous potential to change adult behavior. If you are a parent, you probably have experienced this. Organizations should consider forming coalitions with chambers

of commerce and school systems for maximum impact on the entire community.

It is important to emphasize that prevention, regardless of the affliction, is a personal issue. Organizations can go to great lengths and reduce risks significantly but, ultimately, each individual has the greatest opportunity to limit her or his own risk. Educators, supervisors, and management should reinforce this message often. The individual has more control than anyone else when it comes to good health.

Toward this end, children and adults should be taught early and often that they can take care of themselves, they can achieve, and they can lead fulfilling work and non-work lives. But it is mainly up to them and the choices they make. Organizations can teach and reinforce attitudes of self-responsibility through their actions and by training supervisors to deal with workers appropriately. By supporting, rewarding, and reinforcing healthy lifestyles, individual risk reduction, and self-responsibility, business and industry can stem the rise in illness and injury while maintaining healthy profits.

Whenever we attempt to effect a behavior change, it is important to remember what motivates. People do things or don't do them (whether it's watching TV, eating fast food, or taking risks) because years of reinforcement have taught them that this is the way to be. When designing behavior-change programs, it is not enough to ask people to change because it is good for them. People have to feel it. In other words, you have to answer the WIIFM (what's in it for me) question.

If you adhere to the principles outlined above, you can get people to move in a desirable direction. It is not enough to simply point out that they will feel better and save the organization money. Regardless of the health problem or opportunity you are trying to address, following these steps will improve your chances for success. ■

The Role of Prevention in Health Care Reform

Judy Feder, Ph.D.
Principal Deputy Assistant
Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

AT THIS MOMENT, the outcome of our efforts to pursue health care reform continues to be in limbo. We will continue to pursue a comprehensive reform proposal with the democratic leadership of Congress when they come back into session. Along with the Administration, we have been supportive and will continue to be supportive of Congress's efforts. We look forward to seeing the results. I can't speak to you about the outcome right now, but I can talk about the key elements of the debate.

> *"What you can read from our initiatives in this Administration is that we have a very strong commitment to prevention with or without comprehensive reform."*

Specifically, when I talk about health care reform, I wish to remind us all of the importance of comprehensive health reform and why we as an Administration have been so committed to it. But there are many barriers to achieving comprehensive health reform. Despite these problems, certain elements, including prevention, must be pursued, regardless of what happens in this congressional session. So, for starters, let me talk about why comprehensive health reform is so important. There are two fundamental issues here. One has to do with what I call the human issue, which involves access to appropriate services when they are needed. The other has to do with physical stability in both the private and public sectors.

It is widely recognized that without insurance coverage there is a risk of limited or

inappropriate access to care. Over the years there have been debates about the care that everyone should receive with or without insurance. Currently, persons without insurance can get some services, even some expensive services. But it would be wrong to argue that people without insurance are appropriately served. It is also recognized that insurance alone is not sufficient to address people's needs for health care. This is certainly true for persons with disabilities who often need additional services. Few would disagree with the statement that insurance is a necessary condition, though not a sufficient condition, for assuring appropriate access to services.

The second issue has to do with fiscal stability. As long as we have people who are not participating in assistance, we have a continuing and difficult problem of cost shifting that makes it very difficult, if not impossible, to focus our system on the efficient delivery of quality care. The public sector, which limits what it pays for care, shifts costs to private payers who are unable to negotiate effective or acceptable insurance rates. The private sector often screens patients and takes the least difficult ones, shifting costs to the public sector and public programs. All of this cost shifting makes it very difficult to promote efficiency in our health care system. We need a delivered system, which is the only way to make it affordable. It is for this reason that we are very committed to a system in which everyone participates and in which everyone pays their fair share. This explains why we have pursued universal coverage; but we all know that the pursuit has faced extremely serious and powerful obstacles.

Many question the goal and capacity of government to pursue reform. But has there been an alternative? Without federal guidelines, the private marketplace has brought about a decline in coverage and shift of cost. Many question whether we can afford to cover everyone despite the fact that, even if everybody does not get appropriate care, we are all paying for the care of those who do not have insurance—and their care is often inefficient and ineffective. Perhaps the real question is whether we can slow the rise of health care costs without threatening quality and choice, in spite of the fact that we are seeing less choice and a diminution in the quality and continuity of care under the current system.

The big picture is, in large part, ideological. It concerns design initiatives, private insurance, and issues related to guarantees of choice in promotion of quality. The greatest difficulty has not been responding in terms of design to these kinds of concerns. It has been the use of these concerns in public debate by interest groups that do not seek comprehensive health care reform and use tactics to scare, rather than educate, the American public. Sadly, these scare tactics have led many segments of the American public to prefer the status quo over any kind of reform. We see this in the insurance industry which, even though comprehensive insurance reform

would expand the purchase of private insurance, has been less concerned with what it would gain from this movement than with losses in terms of new rules for insurance practice. We see it in providers who have profited from having everyone who comes in for service pay for their own care, but we have become more sensitive to concerns that efforts at cost containment would make them worse off than what they would experience in a reformed health care environment. And we see it with big and small businesses that are concerned that their obligations to pay under a reformed system will outweigh any efforts that are introduced to contain costs. These concerns have been enormously disturbing and, in many ways, legitimate. However, they often have been used in ways that have, I would argue, frightened the American public. As we came into this debate, I would say the public was indeed something of a tic point. For many years, in fact when I staffed the U.S. Bipartisan Commission on Comprehensive Health Care about five years ago, there was concern about general problems and issues in the health care system. There was recognition of a national health care problem, but the general attitude was that the problem was someone else's problem. It was felt that the problem was for an unfortunate minority that fell through the cracks. When this debate began during the last presidential campaign and when the Clinton Administration first took office, we saw a very different perspective among the public. We saw a recognition and a fear that the insurance many of us have come to count on is, in fact, at risk. One in four Americans over the course of a year is without health care coverage. This really means that virtually any of us is at risk, at any time, of losing coverage and the access to care that it brings. This concern has fueled the debate and it continues. But people's fears under the current system did not lead them to welcome any change that would be put on the table. People were also very concerned about whether reform would make them worse off rather than better off. What has happened in this debate is that fear has reached a very high level and made it very difficult to move forward. Although some concerns are legitimate, the reality is that well-thought-through reform would indeed make us all better off.

The challenge, really, is to overcome the fears. It remains to be seen whether we have been successful, but we can all say that it is an uphill battle. If we look at three critical elements, we can see what the challenges are. The first element is guaranteed coverage for everyone all of the time. It means health care that could never be taken away whether people were or were not working—sick or well, old or young—coverage was guaranteed. And we know we need this to bring an end to the situation that now exists. So the guarantee, we believe, is very important. The second element involves changes in insurance practices to bring an end to discrimination against people based on health status. This discrimination works exactly counter to the purposes insurance seeks to serve. My intent is not to portray this as an evil practice.

I believe insurers are simply following the incentives of the marketplace. In situations where access to insurance is voluntary, insurance is expensive. In the absence of rules, it is clear that an insurer can offer a lower price if it does not cover people when they are sick or does not pay for benefits when they get sick. The third critical element is that health reform must focus on changes in the insurance system to better protect seniors and persons with disabilities. Overall, this means providing the same benefits to the medicare population as are provided for the younger population. Even more significantly, this includes major initiatives and major financing for long-term care services, especially for people with chronic disabilities. This has not been a part of the insurance system, and it may never be part of that insurance system unless we pursue a separate and sizable initiative in this regard.

The challenge is obvious when it comes to getting everyone covered and guaranteed with coverage that can never be taken away. We have faced challenges related to employer-based financing, even though we were building on the existing system. The challenges are grave but not unusual for a mandate; this is a new obligation for many employers.

When it comes to changing insurance practices, reform is not easy to achieve. And when it comes to long-term care, even though we designed a program that was not an individual entitlement program but rather entitlements to states to develop long-term health care services, it is challenged as a new entitlement and comes up against the very powerful challenges we face to existing entitlements. Now this is where the attention has been focused, legitimately so, because we have been engaged in trying to change the system on a grand scale. There is, however, underlying support for prevention—the goal to which we are all committed. It is important to recognize that there is a strong undercurrent in this debate for some of the things we care most about. They were reflected in our reform proposal and in other reform proposals in a number of ways.

First, in the benefit package, there is a commitment in most proposals, even where benefits are not enumerated, to coverage of preventive services without any cost sharing. This avoids many barriers to use of services. This commitment to preventive services is evident across the political spectrum.

Second, there is a welcome undercurrent evident in attempts to end exclusions based on preexisting conditions and discrimination based on health status. Without effective rules for rating practices, it is hard to make these rules effective guarantees of affordable access to insurance. But there does seem to be an underlying commitment to eliminating these rules and to mitigating the barriers that currently exist, at least for people who are continually insured. And there is strong interest in the investments that are necessary and that go beyond changes in insurance companies. There is particular support for outreach efforts—transportation and

other support services—so that people can get access to services. Broadly speaking, when it comes to population-based, rather than individual service-based prevention efforts, there is strong commitment to core public health activity, as we have seen in all of the proposals. There is also strong commitment to research in a wide range of areas that have to do with prevention.

We all know that it is tough to achieve these goals without comprehensive reform. But groups like this one are beginning to move the agenda forward. What you can read from our initiatives in this Administration is that we have a very strong commitment to prevention with or without comprehensive reform. Although I have elucidated what the pieces are, the elements of that commitment are in the comprehensive reform package. I need only to point to the children's immunization-proof program, or the recently signed crime bill, or initiatives in women's health or in school health, that are progressing side- by-side with what will be our continued investment in guaranteeing everyone security of health care coverage that is affordable and does, indeed, promote health. So we look forward to working with you, whatever happens in this Congress. ■

REPORTS OF THE DISCUSSION GROUPS

Discussion Group A: Business, Industry, and Labor

THE FOLLOWING IS a summary of the discussions of Group A which addressed topics, issues, and questions about the private sector and preventing disabling conditions from the perspectives of business, industry, and labor.

Question 1: **What should be the role of the private sector in preventing primary and secondary disabling conditions?**

Group A provided four responses to this question:

1. Health promotion and disability prevention should be regarded as a continuum of services across the life span that meet diverse and changing needs.
2. Because the private sector is a diverse group, programming for prevention depends on company demographics, the type of business, its size, and its resources.
3. The private sector has a role to play as educator. Businesses should tell their success stories, spotlighting examples of "best practices." Nothing communicates more effectively to business than the story of how another organization addressed and solved a problem.
4. Return on investment cannot be overlooked. Health and disability are bottom-line issues for employers. Demonstrating the value of cost-beneficial prevention efforts, supported by data, can be highly effective.

Question 2: **What is currently being done in the private sector to prevent disabling conditions?**

The following health and wellness approaches and programs represent the types of activities in which business, industry, and labor engage:

1. Employee assistance programs

2. Work/life programs, including elder and child care
3. Health education
4. Fitness/exercise programs
5. Safety programs, such as promoting the use of seat belts and providing free infant car seats to employees who are new parents
6. Workplace injury prevention programs
7. Programs to prevent back injuries and pain
8. Cholesterol and health screening
9. Disability management, including work hardening programs

There are several examples of programs that have been instituted and have proved successful. The First National Bank of Chicago established a partnership with a health plan to offer an on-site mammography screening program. Los Angeles Power and Light has a corporate lactation program. Sara Lee encourages immunization of children through reminder notices to parents.

Question 3: **What are the steps to consensus in defining the role for the private sector?**

There is a need to do a better job of reaching smaller employers by encouraging the pooling of resources, fostering collaboration and cooperation of small employers, and having them engage in partnerships with the public sector.

Question 4: **What can be done to foster primary prevention?**

Primary prevention should be fostered in the community as well as inside the company. There are some definite steps that can be recommended.

In the community:

1. Encourage the company to become a champion and leader in prevention for the community.
2. Work with corporate foundations to establish the role of "corporate citizen for prevention."
3. Work toward public-private partnerships, such as the Grand Central Partnership and the Washington Business Group on Health. The federal government needs to do a much better job of addressing prevention by resolving conflicting policies and encouraging cooperation between federal agencies with programs in prevention. The role of government is essential, yet there are unintended consequences of bureaucracy and legislation that can actually inhibit creative and progressive prevention efforts. These consequences need to be effectively addressed.

4. Encourage community planning for improvement of community health services, for the institution of prevention programs, and for improved quality of life for all citizens, especially for those who traditionally have been neglected.

Inside the business organization:

1. Use the media to publicize the positive things employers are doing in the areas of health policy, training, and lifestyle.
2. Communicate successes through corporate leadership awards and corporate summits.
3. Continue and expand tax deductibility for wellness programs.
4. Utilize community resources to benefit employees.
5. Incorporate the services of voluntary health organizations for the benefit of employees, such as the "March of Dimes Babies and You" program.

SPECIFIC RECOMMENDATIONS

1. Seek funding for the creation of a white paper or summary document that provides an overview of all work being done in the area of coalitions and partnerships for preventing disabling conditions.
2. Develop a national interest group to exchange information about developments, to network and engage in collaborative research and development efforts, and to provide a forum for cross-fertilization of ideas in preventing disabling conditions.

Participants in Discussion Group A:

Kathy Kirchner, Washington Business Group on Health, Facilitator
Susan Olson, UNUM of America, Resource Person
Miriam Jacobson, Washington Business Group on Health, Facilitator
Dr. James M. Corry, Metropolitan Life Insurance Company, Resource Person
Dean Witherspoon, Health Enhancement Systems, Facilitator
Bonnie Grassi, Marriott International, Resource Person
Russel P. Iuculano, Metropolitan Life Insurance Company
Terrance D. Schiavone, Network of Employers for Traffic Safety
Donald I. Wagner, University of Cincinnati
Cindy Bascetta, U.S. General Accounting Office
George A. Scott, U.S. General Accounting Office
Larry Burt, Centers for Disease Control and Prevention

Discussion Group B: Professional and Voluntary Organizations

THE DISCUSSION GROUP that addressed the role of the private sector in prevention from the perspectives of professional and voluntary organizations raised a number of issues, identified promising developments, and made specific recommendations to be considered by both the private and public sectors.

Obstacles to Progress: What doesn't work in an effort to obtain collaboration between the private and public sectors in prevention?

Among the greatest obstacles to attaining cooperation between public and private sector organizations are:

- lack of clearly defined goals and roles;
- failure to identify the benefits of project participation;
- failure to clarify and meet the expected outcomes of individual members;
- coming to the table with an agenda that excludes others;
- coming to the table for the purpose of using the group to accomplish an individual's own goals;
- participating in the collaborative effort as an inflexible partner;
- raising "turf" issues (this usually results from fear of loss of power or money);
- inability to obtain consensus because the diversity of interests and opinions is so great that consensus is not promoted;
- "parachuting strategies," like trying to impose a white, middle class suburban strategy on an urban, low-income Black or Hispanic neighborhood;
- "mandates" to cooperate;
- insisting that one must go to the "top" of an organization for a representative of the cooperating group or council;
- discounting members by devaluing their participation and contributions;
- not acknowledging group members for their accomplishments;

- informing people and members of the group how to do things rather than asking for their input as strategies are developed.

Facilitators to Progress: What works in an effort to obtain collaboration and cooperation between the public and private sectors in prevention?

Group B turned to strategies that facilitate the development of cooperative efforts between the public and private sectors. These strategies include the following:

- Clearly delineate the purpose and mission of the "coalition."
- Clearly delineate the role of each participating organization.
- Before bringing the coalition together, develop a clear plan with short- and long-term objectives. The draft plan will facilitate the discussion of the need and the role each participating organization will play.
- Before the first meeting, learn about the "players," get to know them on a one-to-one basis to identify common ground for building relationships and helping to identify roles.
- Identify why groups and individuals should participate. Ask what the *benefit* is for them. Learn what they have to offer and what others have to offer them.
- Certain geographic areas may be more motivated to seek collaboration because of limited resources. For example, prevention programs in rural areas may not be feasible unless all available resources are coordinated and participating organizations cooperate for the greater good.
- Choose members wisely to build a strong infrastructure. Identify key participants and their strengths.
- Leaders of the coalition should have good "people skills" for building sound relationships and cultivating resources to sustain the prevention effort.
- Have mixed representation in the coalition drawn from many disciplines.
- Identify potential turf issues up-front. Understand the issues and deal with them so they will not undermine the process.

How do we promote and support the private sector's role in preventing disabling conditions?

Group B made a number of specific recommendations about ways the private sector can be encouraged to participate in preventing disabling conditions. The following represents the major items:

- Institute a program of education to encourage members of the private sector to accept the fact that they have a role in prevention of disabling conditions.

- Offer the private sector an opportunity to be part of a win/win project.
- Develop a project with a marketing strategy and a statement about expected outcomes.
- Everyone's own objectives must be addressed while meeting the needs of the entire prevention project.
- Be patient but persistent in building a true collaboration and cooperation among diverse organizations. It takes time.
- Assist businesses in making their workplaces accessible in a cost-effective manner.
- Study the interests of business in prevention and how disability prevention can relate to these.
- Don't always ask for financial support—seek expertise and technical assistance that in some instances is more valuable than a grant.

How do we encourage smaller businesses to become involved?

A number of suggestions were made to persuade small businesses to participate in prevention projects. The major ones were:

- Business talking to business makes sense. Work through service clubs and chambers of commerce.
- Appreciate that small businesses are trying to survive and we may have to assist them to survive. We may have to help them obtain more customers. We can do this by publicizing the cooperating business through newsletters, forums, and community meetings, and by encouraging members of the coalition to use the business.
- Develop a five-year plan and market it.
- Help small businesses serve people within their own communities.
- Build relationships on a small scale at first; ask for help in small doses.
- In the development of any prevention plan, use local community data in specifying goals and objectives.
- Let businesses and the community know what others have done to prevent disabling conditions.

Participants in Discussion Group B:

Sally Weiss, United Cerebral Palsy Associations, Facilitator
Roberta Carlin, Spina Bifida Association of America, Resource Person
Roger Kingsley, Ph.D., American Speech-Language-Hearing Association, Facilitator

Kathy McGinley, The Arc, Resource Person
Grady O'Rear, Way Station, Facilitator
Roger Chapman, Iowa Department of Health, Resource Person
Jerry Ann Robinson, Texas Office of Disabilities Prevention
JoAnn Thierry, Centers for Disease Control and Prevention
Pamela M. Price, Delaware Disabilities Prevention Program
Glenna W. Gundell, The Arc of New Jersey
Ann Tarpy, Arizona Disability Prevention Program
Judy Bodner, Georgia Office of Disabilities Prevention
Anne Morris, American Occupational Therapy Association
Lynn Feldman, New Jersey Office for Prevention of Mental Retardation and Developmental Disabilities
Diane Paul Brown, Ph.D., American Speech-Language-Hearing Association

Discussion Group C: Independent Living Centers, Consumers and Their Families

THIS DISCUSSION GROUP provided their recommendations according to the three major questions for all conference participants.

Question 1: **What is the role of the private sector in preventing disabling conditions?**

1. Continue to promote discussion and awareness among people with disabilities to promote solidarity on this issue, and to allay fears that disability prevention equates with prevention of people with disabilities.
2. Recognizing the need for data to prove the importance of disability prevention and wellness for people with disabilities, independent living centers (ILCs) and other disability organizations should actively assist and participate in the collection of data for research and should contribute to the establishment of a computerized data base. Information from consumers and dissemination of results should be emphasized.
3. Through advocacy efforts spearhead by ILCs, educate the rest of the private sector and the public sector about the fact that everyone needs a wellness plan and that wellness and prevention must be incorporated into all long-term planning. Private corporations can assist with marketing techniques.
4. Keep emphasizing wellness and prevention as both quality of life and cost-cutting strategies.
5 Expand the range of people and organizations involved in advocacy. The entire community, for example, should advocate for accessible recreation facilities.
6. Encourage membership of people with disabilities and their advocates on corporate boards, school committees, and other decision making bodies to promote wellness and disability prevention.
7. Encourage people with disabilities in the corporate world, who are not

connected with the disability movement, to embrace and promote the issues of wellness and secondary disability prevention for people with disabilities.

Question 2: **How do we promote and support the private sector's participation in preventing disabling conditions?**

1. Follow the example of ILCs in Mississippi that gained attention for prevention issues through newspapers, TV, billboards, health fairs at malls, joint efforts with insurance companies and drug companies.
2. Conduct public and private sector forums, usually on a specific issue, to exchange information and to network with the private sector. Coalitions can be formed to clarify who should spearhead what issue. ILCs can add corporations to their mailing lists and include executives on advisory boards.
3. Establish a national clearinghouse to collect and disseminate information on wellness and prevention and to do research and training.
4. Enlist support from all community groups that support improved health care.
5. The American Disability Prevention and Wellness Association should spearhead a debate, on the local level, to encourage ILCs to become involved in prevention. A first step might be to approach NCIL and other organizations to place wellness and prevention on conference agendas.

Question 3: **The private sector/public sector connection: points of cooperation in preventing disabling conditions.**

After a general discussion of the need for ILCs to market their services to corporations and other groups in the community, the following recommendations for contact points regarding wellness and prevention were made:

1. In regard to good public/private connections, some natural points of contact between ILCs and other entities in the community are Americans with Disabilities Act-related issues like consultation, education, and compliance with the Workers Compensation System. (Three fourths of workers' compensation costs are wage continuation.)
2. Schools provide another opportunity for ILCs to collaborate with the community, conducting awareness programs and providing mentors and role models.
3. Professional associations (of physical therapists, nurses, etc.) may provide opportunities for ILCs to be involved in training for continuing education units.
4. ILCs should raise community awareness about the lack of accessible recreation and wellness programs for people with disabilities. Some ideas for this include

initiating a national campaign, promoting wheelchair and other disability-related sports in the larger sports community, and advising private sector directors of recreational facilities about the "how to" of accessibility with the benefit of attracting more business.

5. Given limited resources, ILCs should choose target groups which have the greatest needs and are good candidates for successful outcomes.
6. Enlist the media's help in emphasizing wellness and quality of life for people with disabilities; cover this topic in newspaper health inserts, etc. Encourage the media to promote inclusion in all wellness programs.
7. ILCs should work with insurance companies to adapt wellness programs and promote research on wellness and secondary disability prevention for people with disabilities.
8. The concept of aging is a natural point of contact for ILCs and groups focused on aging, like the AARP. ILCs have expertise on accessible home modification, transportation, recreational facilities, etc., to offer to older Americans.
9. Vocational rehabilitation agencies can fund wellness education and programming through ILCs. These agencies should be considered experts on adaptive equipment and ergonomics to promote lifetime wellness and secondary disability prevention through their use.

Participants in Discussion Group C:

Dot Nary, SUNY Health Science Center at Syracuse, Facilitator
Peter Leibert, Arc Prevention Committee, Resource Person
Dyanne Bostain, Ph.D., University of Virginia, Facilitator
Christy Gilliland, Advocate for Persons with Disabilities and Consumer, Resource Person
Paul Hearne, Esq., Dole Foundation, Facilitator
Dawn Taggart, New York State Department of Vocational and Educational Services for Individuals with Disabilities, Resource Person
Ray McNeece, Estate Planning for Persons with Disabilities
Glen W. White, Ph.D., University of Kansas
Sunny Roller, University of Michigan
Dana Gigliotti, Delaware Division of Public Health, Disabilities Prevention
Gina Gentry, Arizona Department of Health, Office of Disabilities Prevention
Sherry Billings, District of Columbia Disabilities and Injury Prevention Program
James Hollahan, Organizational Development Systems, Silver Spring, MD
Roger Harrell, Division of Injury and Disability Prevention and Rehabilitation, Baltimore, MD
Michelle Herron, Kansas Department of Health and Environment

Valerie Watson, Delaware Disabilities Prevention Program
Richard Cunningham, Ph.D., University of Virginia
Ken Golden, University of Kansas
Soledad Chavarria, Department of Education, Costa Rica, C.A.
Belai Habte-Jesus, M.D., MPH, Washington, DC, Commission of Public Health
Brooke Lindsay, U.S. Department of Health and Human Services
Roland Follot, District of Columbia Arc.

Discussion Group D: Private Health Agencies, Rehabilitation Centers, and Hospitals

GROUP D PROVIDED the following preamble for their deliberations and recommendations:

PREAMBLE

It proved challenging to regard hospitals and rehabilitation centers as elements of the private sector, inasmuch as public funding is such a significant portion of their total operating budgets. Even private health agencies commonly receive significant governmental support. Obviously, however, there are differences in orientation.

Hospitals and rehabilitation centers normally work through privately and locally derived charters and governance systems. Various types of accreditation are required to qualify for reimbursement for services and to secure accepted roles and positions. Compliance includes attention to sound professional standards, safety, and human rights.

There is a considerable range of functional characteristics for these facilities. Leadership in social programs and other outreach opportunities may or may not be creatively utilized. Our group feels that the prevention capacity of hospitals and rehabilitation centers will be much influenced by the degree to which their service design is holistic and has long-term commitments.

The group felt that the orientation of the conference tended to focus attention on the prevention of secondary disabling conditions as applied to primary disabling

conditions. Virtually all of the group's activities and relationships pertaining to the role of the private sector dealt with concerns about secondary conditions. To put these items in some logical order, the group drew upon the Institute of Medicine's system of "Components of a Comprehensive Prevention Program" (see Chapter seven of *Disability in America*, Washington, DC: National Academy of Sciences, 1991). There are five component groups:

1. organization and delivery of services
2. availability of appropriate assistive technologies
3. adoption of health-promoting behaviors
4. education and information
5. environmental considerations

These five component groups will form the basis for recommendations as they relate to the role of hospitals, rehabilitation centers, and other health agencies.

Planning and coordination of care:

- provision of care coordination after discharge
- design of continuing services that are accessible, involve home visits by physicians and other health providers, and are user-friendly
- collaboration among providers for long-term health resources and supports in the community
- offering respite programs for parents or caregivers
- partnership between private rehabilitation organizations and federal agencies on description of individual capabilities, especially definition of disabilities

Individual learning and self-help related to prevention behaviors:

- teaching patients to be more responsible for their health, (including urinary tract infections, skin care, alcohol and tobacco use, mental health measures, etc.)
- dealing with issues of social adjustment and independence early in training
- increased availability of exercise equipment

Improved information transfer and technical assistance:

- hospitals should provide data on E-coding and trauma
- systems for data collection on outcomes
- continuing needs assessment in the community regarding people who have disabilities
- technical assistance for teachers who are integrating children who have had trauma or who have disability
- health education activities in shopping malls, using partnerships and chambers of commerce

Work with the setting and environment:

- hospitals and centers should provide model compliance with regulations of the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973, as amended
- pool efforts to institute wellness programs for smaller, self-insured facilities.

Participants in Discussion Group D:

Allen Crocker, M.D., Children's Hospital-Boston, Facilitator
Sylvia Walker, Ph.D., Research and Training Center for Access to Rehabilitation and Economic Opportunity, Resource Person
Don Lollar, Ph.D., Shephard Spinal Rehabilitation Center, Facilitator
E. Elaine Vowels, Ph.D., District of Columbia Department of Human Services, Resource Person
Mary Evert, American Occupational Therapy Association, Facilitator
Theda Zawaiza, Ph.D., U.S. Department of Education, Resource Person
Doug Smarte, Arlington, VA
Ray Petty, Kansas Department of Health and the Environment
Theresa Chase, M.A., Craig Hospital, Englewood, CO
Theresa Paeglow, New York State Disabilities Prevention Program
Michelle Mathers, Delaware Disabilities Prevention Program
Robert Demichelis II, National Head Injury Foundation
Tom Seekins, Ph.D., University of Montana
Susan Higgins, U.S. General Accounting Office
Corinne Barnwell, MSW, Louisiana Disability Prevention Program.

Discussion Group E: Schools (Elementary, Secondary, and Postsecondary)

DISCUSSION GROUP E addressed each question with the following comments and recommendations:

Question 1: **What is the role of the private sector in preventing disabling conditions?**

An overview was presented by the group resource person, Dr. George Schmidt. He stated that schools are not providing children with the tools they need to succeed. As a nation, we spend hundreds of billions of dollars on repair and remedial services; we need to invest more of our nation's resources in prevention. Also, business is saying to the public sector that we need to collaborate more, because what school systems do affects private industry.

The group also identified key issues, concerns, and problems. School systems do not fit within the public, private, or nonprofit sectors as these sectors are customarily defined. The constraints on private industry are very different from those related to school systems. Schools find it difficult to communicate with the private sector. The expectations of school systems are very different from the expectations of the public sector. The following recommendations were proposed:

1. Schools need to be community centers. Parents and retirees within a school district can be utilized for projects requiring human resources.
2. Schools need to forge partnerships with business and industry with incentives for all partners to regularly collaborate on projects of shared interest. Schools can learn about effective networking strategies from the private sector.
3. We must address prevention of secondary disabling conditions in children with disabilities in the school system. Preventive strategies could include

sex education for students in special education to prevent sexually transmissible diseases; education about good nutrition, diet, and exercise to prevent cardiovascular disease, pulmonary disease, stroke, and weight problems; and teaching children about personal responsibility for safety and avoidance of hazards.

4. We need to identify quality curriculum materials in prevention to be shared with teachers through electronic networks.
5. During the "transitional period" in high school for children with disabilities, private sector employees need to learn about making worksite accommodations to prevent secondary disabilities.
6. Facilitate the transfer of private sector assistive technology into the school system.
7. School should be in session on a year-round basis (12 months).
8. We need to make better use of transitional services by the private sector.

Question 2: **How do we promote and support the private sector's participation in preventing disabling conditions?**

Successful models that have worked in various communities were discussed. These include the following:

- In South Carolina, a curriculum on disability prevention was developed that included lesson plans that could be integrated within existing classes, including biology and health education.
- In Virginia, a Head Smart Program project was developed with the support of the National Head Injury Foundation and Upjohn Pharmaceutical Company.
- Access Excellence, underwritten by Genentech, is a curriculum developed to provide genetics information for biology classes.
- In Missouri, a safety training/basics of bicycling class has received the attention and sponsorship of the police.

The group believes that it is crucial to obtain acceptance by teachers. In addition to having pertinent and meaningful materials available for classroom use, it is very important that teachers are informed about disabling conditions and ways we may prevent them.

If teachers become partners in prevention and communicate their interest and concern, this will have a favorable impact not only on students, but also on their parents. Through parents, the community and business will be brought into programs to prevent disabilities. The prevention efforts could incorporate valuable human resources in the school's community: parents and retirees in the community,

school board members, school administrators, and students themselves.

A strong recommendation was made for funding someone or some group to develop a compendium of model prevention programs.

Students need to learn more about disability and the ways in which primary and secondary disabling conditions may be prevented. This information should be incorporated into the school health program, physical education program, or science classes. Children with a disability should be informed about the causes and prevention of secondary disabling conditions.

In addition to instituting curricular modifications in the schools so that all children are informed about disability prevention, the group recommends that schools be used as community centers. Because the regular school day is already overcrowded with activities, it was suggested that "after-school time between 3:00 and 5:30 pm" could be used to incorporate prevention programs and educational activities. This period of time is often available to students, and working parents often seek ways to fill this time with productive activity.

The value of networking cannot be underestimated. Schools need to develop partnerships with the local business community, a relatively new role for schools. This is important for helping students make the transition from school to a work environment. It could include anything from having business people give presentations at the school to a mentoring program in which professionals become role models and students gain experience in the work setting. Such activities help to develop positive self-image in students and give them "a sense of their future."

Companies would be encouraged to participate in prevention projects if tax incentives were available. Marriott International, Inc., was identified as a model company that has worked in easing the transition of students with disabilities from school to work. Such outstanding efforts should be publicized through the print and electronic media.

Question 3: **The private sector/public sector connection: points of cooperation in preventing disabling conditions.**

The discussion group indicated that it is important to recognize that schools have "clout." In addition to their role in the community as leaders and supporters of good things, schools have strong volunteer groups, including parent-teacher associations. They need to take responsibility for participating in prevention planning and related activities. Also, the school environment needs to foster prevention as a way of life as an explicit learning experience, similar to nutrition education and nutritious and balanced school lunches.

RECOMMENDATIONS:

1. Education laws should be consistent across the country.
2. Standards and goals for special education should be consistent across the country, like those developed by the National Association of State Directors for Special Education.

   Action steps:

   a. Assess efficacy of NASDSE standards for prevention.
   b. Assist states in implementing prevention programs through schools.
   c. Work with schools and communities to obtain funds and maintain and expand standards.
3. Establish national, state, and school-based prevention committees.

   Action steps:

   a. Collect data on successful school-based, collaborative prevention models.
   b. Establish affiliations with private sector organizations to sustain models and develop recommended standards for prevention programs for education.
   c. Develop marketing strategies for implementation in the schools and to attract private sector support for a clearinghouse of information about prevention.
   d. Include participation by other state agencies and colleges and universities within the state.
   e. Evaluate and monitor school policies and standards for programs preventing primary and secondary disabling conditions.

Participants in Discussion Group E:

Laverdia Roach, President's Committee on Mental Retardation, Facilitator

George A. Schmidt, Ph.D., Florida Department of Health and Rehabilitative Services, Resource Person

Debra Rothstein, Ph.D., Office of Disease Prevention and Health Promotion, DHHS, Facilitator

Peter Sheras, Ph.D., University of Virginia

Deborah Cohen, Ph.D., New Jersey Office of Prevention, Facilitator

Adelaide Farrah, Ed.D., Organization of American States, Resource Person

David Hamel, Rhode Island Disabilities Prevention Program

Donna Scandlin, University of North Carolina-Chapel Hill

Joseph Patton III, District of Columbia Bureau of Disabilities and Injury Prevention

Suzanne McDermott, Ph.D., University of South Carolina School of Medicine
Mary S. Johnson-Gerard, University of Missouri
Doug Browne, DPP, Centers for Disease Control and Prevention
Mike Adams, M.D., DBD&DD, Centers for Disease Control and Prevention.

Discussion Group F: Health Professions

THE FOLLOWING IS a summary of Group F's deliberations in response to the first question, *What is the role of the private sector in preventing disabling conditions?*

Health professionals have a role in

1. identifying disabling conditions and their effect on individuals;
2. researching causes of disabling conditions and applying epidemiological studies to determine trends;
3. instituting or participating in prevention programs that attempt to eliminate risks of premature death and disability, recognize early signs of disability, and minimize secondary conditions;
4. instituting tertiary prevention for cases that demonstrate a disability;
5. assuming an advocacy role in prevention within the professional's community;
6. participating in public education programs addressing the need for prevention that is aimed at both the public and private sectors;
7. functioning as a change agent for public and private sector initiatives in health care by including prevention.

Health professionals also can play roles in encouraging medical schools to include information and training in prevention; physicians need to change their attitude toward health care from a total focus on crisis intervention to crisis intervention and prevention; and the health profession should advocate for accessibility for all to excellent primary health care.

Recommendations for action regarding the first question include:

1. Medical education programs for health care providers, especially physicians, should teach people skills; how to be more humanistic and sensitive to the

needs of the patient and the family.

2. Physicians and nurses should provide health promotion strategies to their patients before they are discharged from a health care facility. Each patient should be provided with an individual "health promotion and health education plan."
3. Incentives should be established to encourage application of prevention strategies in health care for all providers—health care practitioners, consumers, and decision makers in the private sector.
4. The practice of "dumping everything on the primary care physician" needs to change. A team approach to patient care should be instituted with the addition of a prevention specialist who works closely with the physician, nurse, and other health care professionals.

Group F then addressed the second question, ***How do we promote and support the private sector's participation in preventing disabling conditions?***

The first major point made was that at the present time, health care and the role of prevention is affected by the political climate. Dollars for research and training in health care are declining. The private sector needs to bridge the gaps left open by the federal and state governments' approaches to health care. Recommendations include:

1. Establish a clear understanding and definition of prevention so that the private sector knows its role.
2. Communications with the private sector about prevention should be clear, sensible, and to the point.
3. Rehabilitation professionals need to communicate about prevention programs with other health care professionals, especially physicians and nurses. We need to get on agendas at medical meetings and suggest materials on prevention for the curricula of medical and nursing training programs.
4. Establish better protection and advocacy systems to assure accessibility to and continuity of good health care for consumers.
5. Provide more consumer training on how to become better health consumers, stronger advocates for improved health care in the United States, and supporters of consumer rights.
6. Institute pilot projects in prevention programs that define data, outcomes, evaluation of need, and effectiveness of interventions.
7. Work with colleges and universities to introduce courses on prevention for health care providers and consumers.
8. Create incentives for health professionals to institute and engage in prevention programs. One of the incentives should be financial

compensation for professional activity in prevention.

9. Create training teams to work with private groups on the importance of prevention and how to become involved.
10. Develop guidelines and standards on the basic levels of care, including prevention strategies.
11. Action steps to spread the word about the significance of prevention include: bridge gaps with private sector funding and support, change/soften our language about health care and the role of prevention, communicate the importance of prevention to health professionals and consumers, and join the information superhighway as another means to disseminate knowledge about prevention.
12. We need to reach health professionals in the same way we have reached employers during the past 30 years—engage in an outreach program and educate them about prevention.

For the third question, ***The private sector/public sector connection: Points of cooperation in preventing disabling conditions***, the following suggestions were made:

1. Health professionals need to contact foundations and corporate giving programs of business and industry to learn their research and program agendas. If prevention is not part of the agenda, we should recommend that prevention be included.
2. There is need for more collaboration between health professionals in the public and the private sectors and between clinical and public health.
3. Using *Healthy People 2000* as a framework, bring together private and public policy makers to learn how to promote employee health that includes persons with disabilities. If a public/private coordinating group is already established, it may be helpful to begin with the priorities of the group and suggest that they add prevention. Or, if a group does not exist, develop one with key representatives from the public and private sectors. County health departments have been effective in some instances in bringing people together to engage in community health assessments.
4. Work through chambers of commerce to identify local community private sector participants.
5. Use schools to educate children about health promotion and wellness.
6. In the process of encouraging inclusion of prevention programs in health care, we need to find the right incentives to maintain support and interest and we need to find ways to reduce the paperwork that has plagued other health care initiatives.

7. Current data is needed in three major areas:
    a. Prevention of impairments and primary disabling conditions
    b. Prevention of secondary disabling conditions
    c. Promotion of wellness and improved quality of life
8. An example of collaboration between the public and private sectors could include the following:

Research and Education Regarding Prevention

Public	*Private*
• National Center for Medical Rehabilitation Research	• Private Data
• National Institute for Disability and Rehabilitative Research	• American Hospital Association
• Centers for Disease Control and Prevention	• American Public Health Association, American Medical Association

9. The CDC should institute a new approach to the utilization of its funds for prevention. Each state should be encouraged to establish a private/public sector coordinating council on prevention with a long-term plan of action and a timetable for its implementation and assessment. Programs could be financially supported based on evidence of movement toward the objectives in the long-term plan.
10. Five points of collaboration between the private and public sectors are as follows:
    A. Research
        1) Institute projects in outcomes research on topics of specific interest to the foundations and business/industry.
        2) Expand knowledge base, including better understanding of primary and secondary disabling conditions. Collaborate with the National Institute for Disability and Rehabilitative Research, National Center for Medical Rehabilitative Research, Centers for Disease Control and Prevention, and other agencies of the Department of Health and Human Services.
    B. Education and Training
        1) The public sector should introduce prevention into the training programs of health professionals at the preservice and inservice phases of education.
        2) Similarly, private sector education should include prevention knowledge and intervention skills at the preservice and inservice

phases. In addition, health professional organizations should educate their members about the practice of prevention in health care.

C. Business-Employee Health
   1) Public and private sectors need to effectively respond to the ADA and work toward the goal of wellness for every individual. As an example, government agencies and business/industry organizations should strive for employee wellness.
   2) Provider incentives need to be introduced to increase the application of prevention programs by health professionals and insurance companies. For health professionals, these incentives may include reduced paperwork, financial support for applying prevention interventions, and societal acclaim and recognition for reducing the incidence of chronic, severe, catastrophic disabling conditions. For the insurance industry, incentives may include reduced paperwork for government reimbursement, considerably reduced cost of disability through prevention, and societal acclaim for reducing primary and secondary disabling conditions.

D. Advocacy and Public Awareness
   1) The public sector should apply wellness education for self-employed and unemployed persons.
   2) The private sector should utilize its marketing skills to communicate the wellness message to the public.

E. Unmet Goals for Prevention
   1) A definitional and standards conference is needed to resolve
      a) the meaning of the terms "prevention," "health promotion," and "wellness," and
      b) the criteria for assessing excellence in the application of prevention programs and methodologies.

Participants in Discussion Group F:

Don Blankenbaker, M.D., Erlanger Medical Center, Chattanooga, TN, Facilitator
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Elaine Eklund, Ph.D., Association for University Affiliated Programs, Resource Person
Melinda Pavin, MPH, SUNY Health Science Center at Syracuse, Facilitator
Margaret A. Turk, M.D., SUNY Health Science Center at Syracuse, Resource Person
Angela Ford, Missouri Office of Head Injury Services

Stephanie Toliver, National Head Injury Foundation
James W. Hanson, M.D., Department of Health and Human Services
Raymond Seltzer, M.D., Department of Health and Human Services
Belai C. Habte-Jesus, M.D., MPH, District of Columbia Government Department of Human Services.

SUMMARY OF PLENARY SESSION

Plenary Session: Summary of Group Discussion

NEAR THE END of the conference, participants met to review and summarize their observations and recommendations concerning the role of the private sector in preventing disabling conditions. The results were as follows:

Institute Prevention Programs at Local Community Levels.
For prevention to work effectively, it must relate to problems within the local region. In initiating a prevention program to reduce disabilities resulting from vehicular crashes, for example, it is more meaningful to speak about the numbers of individuals disabled as a result of vehicular crashes within the community during a one-year period than to present statistics about the total number of persons disabled by such crashes throughout the United States.

Each Community Needs a Leader with "Spark" to Institute Prevention Programs.
Effective programs for prevention begin with people who have the dedication and people skills to initiate and implement a program of prevention at the local, state, or national level. It is individuals working together that makes prevention happen. We need to identify these individuals in each community and encourage their participation. Although a background in health promotion, health education, and disease and injury prevention is desirable, it is not necessary in the early stages of leadership for the prevention. If a person has the knowledge and training in these areas, it is a plus. A dedicated community leader will learn about these issues as they become intensely involved in a prevention project.

Establish Coalitions Between the Private and Public Sectors.
In developing coalitions, it was suggested that prevention-oriented businesses be recruited to communicate and encourage the participation of other businesses. Also, prevention-oriented individuals who are members of business advisory boards and boards of directors have been effective in persuading business/industry to become involved in prevention efforts within their own organizations as well as in the

community. We need to reach out to small businesses, especially, because they usually are overlooked and because they represent an important segment of the private sector. Pharmacies, for example, could become a significant persuasive force for the application of preventive measures in the community.

Rewards and Incentives to Participate in Prevention Programs.
Participants urged that we identify effective ways to reward individuals, businesses, and corporations for their involvement in collaborative prevention projects. Recognition of the contributions of groups and agencies from both the private and public sectors is essential. A good beginning point would be to develop a plan for cooperating on special prevention projects, like seminars and workshops. The general public will perceive these cooperative efforts as validation that the private and public sectors are cooperating.

Specific Recommendations About the Role of the Private Sector in Preventing Disabling Conditions.
Health promotion and disability prevention should be regarded as a continuum of services that spans across individuals' life spans addressing diverse and changing needs. The private sector is a diverse group; program involvement depends on a broad range of issues, including company demographics, the type of business, its size, and its resources.

1. The private sector has a role to play as an educator or at least as a coalition interested in raising awareness about health care issues related to prevention.
2. Businesses should tell their success stories so that the public in general becomes informed about best practices in prevention. Nothing communicates more effectively to business than a story of how another company has addressed or solved their employee health care problems and implemented outreach programs to the community.
3. Businesses involved in prevention should address the question of "return on investment." If the cost-effectiveness investment in health care with prevention is substantiated, the success should be publicized. Health and disability management is a bottom-line issue for employers. We need to invest in the cost-beneficial prevention efforts supported by good data. Some of these efforts include employee assistance programs, work-life programs, health education, fitness and exercise, safety programs, injury prevention, back safety, cholesterol and health screening, and disability management.
4. In addition to introducing prevention in health care programs for employees, employers should be encouraged to participate in collaborative community efforts for preventing premature death and disability.

5. Leaders in community prevention programs should seek support from both public and private sources. Cooperative arrangements with corporate foundations can become important sources of support.
6. The concept of public/private partnerships in prevention should be emphasized. An example of this is the Washington Business Group on Health. The federal government needs to do a much better job of addressing prevention by reconciling conflicting policies within various departments and agencies of the government. Improved intragovernmental cooperation sets the stage for improved private/public sector partnerships.
7. Federal and state governments need to expand tax deductibility for prevention and wellness programs.
8. Corporations, especially large ones, should utilize community resources to benefit employees. Many corporations have instituted health promotion, prevention, and wellness programs in addition to what is available in the community. Utilization of community resources is often cost-effective and improves the "good neighbor" image. Also, many communities have active volunteer health organizations that could provide other means to cut health care costs.

The Role of the American Disability Prevention and Wellness Association. Two recommendations for the Association were made to facilitate the development of public/private sector partnerships. First, the Association was asked to create a "White Paper" or "Summary Document" of the prevention efforts by coalitions and partnerships so that there can be one source for interested parties to consult. The second recommendation related to the need for the Association to establish various interest groups to meet the diverse needs of the growing membership. Comparable to the categories of the discussion groups for this conference, the Association may establish six or seven interest groups under the general goal of preventing disabling conditions.

The Meaning of the Term "Disability Prevention." There is a need to promote discussion and awareness among people with disabilities to clarify the meaning of disability prevention—that it does not mean the prevention of people with disabilities. It means the prevention of primary disabling conditions in persons who are not disabled and the prevention of secondary disabling conditions in persons with disabilities. The focus is on the prevention of the disabling condition, not the person. Although everyone supports the concept of preventing premature death and disability, despite the amazing progress in prevention, we still cannot prevent all disabling conditions. When an individual becomes disabled,

every effort should be made to restore the individual's abilities to the greatest extent possible, stabilize them, and take steps to prevent their deterioration over time and to prevent the acquisition of additional health complications that could result in secondary disabling conditions. The term "disability prevention" is not intended to demean or depersonalize an individual—it refers to the process of preventing disabling health conditions for all Americans.

Membership of People with Disabilities on Corporate Boards, School Committees, and Other Decision Making Bodies.

On the assumption that everyone needs a wellness plan and that wellness and disability prevention must be incorporated into any type of long-term planning, it is suggested that people with disabilities become members of boards and committees that establish policy and oversee planning for public and private sector organizations.

Using Sound Marketing Techniques to Educate the Public About the Importance of Prevention.

Community groups interested in instituting programs for prevention should contact private corporations and draw upon their expertise in marketing ideas and products. The independent living centers in Mississippi have been engaged in an effective program of public education with the cooperation of the state disability prevention program. The plan includes use of public media—newspapers, television, and billboards—and use of health fairs throughout the state to disseminate the message of prevention. The Mississippi example points out the potential effective role of the independent living centers in promoting programs for prevention and wellness.

Cooperative arrangements with other groups in the community are encouraged. These include professional associations representing health and health related occupations including physicians, dentists, nurses, physical therapists, occupational therapists, speech-language pathologists and audiologists, recreational therapists, rehabilitation counselors, elementary and secondary school teachers, and health educators.

Rehabilitation and Disability.

Rehabilitation services need to advocate and support people with disabilities throughout the individuals' lifetimes. The current role of rehabilitation is to follow the person with disability from the primary care period, through the vocational education and retraining period, and into the first job placement. Then the individual is left to "fend for himself or herself." It is strongly suggested that the state and local rehabilitation services agencies assume responsibility for managing a case

beyond the first job placement and that they extend support and counseling throughout the lifetime of the individual as needed. The rehabilitation services agencies should promote healthy lifestyles and wellness for their clients at all times. A person with a disability should emerge from their rehabilitation program with a personal commitment to attaining and maintaining the greatest degree of good health.

Recommended Incentives for the Private Sector to Focus on Prevention. Hospitals and community health agencies should consider the following as possible incentives to become involved in community activities related to prevention and wellness:

- good public relations for the organization
- credibility of the organization
- capacity for greater self-regulation
- generation of new income
- improved cooperation of consumers
- improved long-term work force
- increased capacity to gather data about progress in health care
- targeted tax benefits

These organizations should encourage their employees to join community health agencies as volunteers to promote prevention and wellness. A caution about the growing isolation of managed care programs and facilities was voiced. It is important to remind individuals in managed care not to lose contact with their communities. When health care is compartmentalized, it becomes less effective. A holistic approach to health care that includes community involvement is essential.

Private and Public Sectors Can Readily Collaborate in Four Areas. Research, education and training, implementation of the Americans with Disabilities Act (ADA), and advocacy and public awareness represent four areas of collaboration. Jointly sponsored and conducted research projects are needed to expand the knowledge base and understanding of primary and secondary disabilities, their causes, and their prevention. In the area of education and training, preservice and inservice programs in health promotion and prevention should be offered to all employees, especially individuals who are in health and health-related professions. The private and public sectors should continue efforts to effectively implement the ADA in the area of employment of persons with disabilities. Successful placement in an occupation is an important factor in quality of life. The fourth area of collaboration is advocacy and pubic awareness about prevention and wellness. Both sectors should institute programs of public information and health education, not

only for their employees but also for persons who are not employed or are self-employed. The marketing techniques of the private sector can be very helpful in "getting out the message of prevention."

We Need a Common Language for Prevention of Disabling Conditions. In order to facilitate collaboration, we need a common language that relates to prevention, health promotion, and wellness.

An Inventory of Current Prevention Programs and Initiatives. One of the most pressing needs in disability prevention is the development of an inventory or catalog which identifies current efforts in prevention throughout the nation and the world. But it is not enough simply to list identifying information about these programs. The important task is to assess the effectiveness of the various prevention programs. Such a catalog will advance the national effort for prevention of primary and secondary disabilities by providing proven strategies and measures in prevention for further application in each interested community.

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